Welcome To Pace Physical Therapy

Please take a few minutes to fill out the following registration forms prior to coming to your appointment. This will allow your physical therapist more time to attend to your physical therapy needs. Please, initial after each paragraph where indicated (including the prescription request form)

Your first visit will consist of a thorough Initial Evaluation.

In addition to being required by law, the initial evaluation is one of the most important components of the physical therapy process. It provides the practitioner with the information he/she will need in order to design a plan of care that best meets your individual needs and requirements.

An initial evaluation will be performed on your first visit, regardless of how many evaluations you may have received in the past by other physical therapists or health professionals.

Once the initial evaluation is completed, the remaining of your session (if any) will be dedicated to your treatment.

Please wear comfortable, loose fitting clothing.

Kindly remember to bring your doctor's referral for physical therapy services.

If you have any questions, don't hesitate to call us at (786) 514-6316,
or email us at jpacept@gmail.com

Looking forward to seeing you!

Sincerely,

M. Julia Pace MA, MSPT, PPRC, CFMT, GCFT

"The definition of insanity is doing the same thing over and over again, expecting different results"
A. Einstein

Do you know the joke that asks how many psychotherapists are needed to change a light bulb? The answer is: only one, but the light bulb needs to want the change.

Now, how many physical therapists are needed to help a single patient? It depends on whether the patient wants to change or not. No amount of therapists or physical therapy will help a patient who wants to feel better but is unwilling to change.

Physical Therapy is a partnership between the patient and the therapist. If you want results from your physical therapy treatment, it would be wise of you to understand your responsibilities as they relate to achieving the results you want.

Many, if not most, of our physical dysfunctions are not the result of an acute traumatic injury, but are consequence of many years of "misusing" our body. Poor postural habits, improper lifting techniques, overuse injuries, overtraining/improper training, pushing ourselves beyond our limits of comfort… these are, among many others, all examples of "bad habits" we tend to acquire in the course of our life. Do they sound familiar to you? If sitting at a desk in front of a computer invariably hurts you neck, is your neck really the problem? Perhaps the problem is in the way you sit in front of that computer, and/or the amount of time you do it for. If you were able to feel discomfort before it turned into pain, and were able to change you position/posture, or improve your support, it's very likely that your neck would not feel like a problem at the end of your day.

If you knew that changing a few habits would prevent you from having pain, would you change them? Careful not to answer this question too quickly, it is not that simple. What if I tell you that most of my patients come to me expecting me to "fix" them? They come to me expecting a passive process of recovery in which the patient is merely the recipient of healing, and not a active participant in the process. Would you identify with them? (If you answered "yes", you are an honest person. You, like most of my patients, have learned to expect that 3 sessions of physical therapy per week should "do the trick", regardless of what you do on your own during the remaining 165 hours of the week. Although it sounds REALLY good, it also sounds a bit improbable, doesn't it?).

Let me make a disclaimer right off the bat: **I can't fix you**. People fix cars, and blenders, and refrigerators. You, on the other hand, are not a refrigerator, and you are not broken. Misused and battered perhaps, but definitely not broken. In need of a helping hand, but not without your own resources.

So… at least in this clinic, physical therapy is indeed a partnership between therapist and patient. One in which I enter into an agreement with you: I will do my best to support and guide you through your own path to recovery, respect your goals and preferences, and listen to your concerns and suggestions. On the other hand, in this partnership, you must enter into an agreement with **yourself**. You must accept that you will have to be pro-active in your own recovery. That "getting better" is not a passive process, that it requires change, and that ultimately it is you yourself who will define the final results of your rehabilitation.

Change is seldom an easy thing to accept or achieve, but always worth the effort when attained. If you are open to the process, it will be my pleasure **NOT** to fix you, but to help you instead.

Ok, let's get to work…

M. Julia Pace MA, MSPT, PPRC, CFMT, GCFP

"If you know what you do, you can do what you want."
M. Feldenkrais

Pace Physical Therapy, 2510 Lincoln Ave, Miami, FL, 33133, Phone: (786) 514-6316, Fax: (786) 221-4970, Jpacept@gmail.com

Pace Physical Therapy

PATIENT INFORMATION:

Name:____ Date of Birth: _________________Sex: M F

Address: ____ZIP Code:_____________

Cell Phone: ______________________________ Home Phone: ________________________________

Email Address: ____

Occupation: ______________________________ Employer: __________________________________

Referring Physician: ________________________________ Phone #: ___________________________

Primary Physician: _________________________________ Phone #: ___________________________

EMERGENCY CONTACT: Name: ____________________________ Relation: ________________

Cell #: _____________________ Home #: ______________________Work#: ___________________

Address: ____

(If patient is a minor, please provide us with the following information:)

Parent/Guardian Name: _____________________________ Date of Birth (of parent):______________

Address: ____

Phone #; Cell: _____________________ Home: ____________________ Work: _________________

HEALTH INSURANCE: Name of ins: ___________________ ID# ___________________________

Group # __________ Primary Insured Name: ________________________Insured Birth Date:______

(please present insurance and personal ID card at the time of service)

AUTO INSURANCE Name of ins: ______________________ Phone #_______________________

Case/Claim#; ____________________________ Date of accident: ____________________________

Adjustor's Name: ____

Pace Physical Therapy
Payment and Office Policy

Primary Insurance

Pace Physical Therapy operates only as a non-participant, out-of-network provider to all insurance companies**.** Pace Physical Therapy does not accept assignment of benefits on insurance claims. **Patients are responsible for paying the balance in full at the time of the service**. Please initial: ___________

As a courtesy to you, Pace Physical Therapy will bill your insurance company in your behalf. **Your insurance company will mail any payments and/or notifications directly to you.** You can check the status of your claims by logging into your insurance's "Member Portal", or by calling your insurance company. **If you have any question regarding claims and payments, please contact your insurance company by calling the number on the back of your insurance card.**
Please Initial: ___________

Also as a courtesy to you, we will verify your insurance benefits. While we will take all reasonable actions to provide accurate benefit information, **be aware that verification of benefits is not a guarantee of payment from your insurance carrier. Please initial: ___________**

We strongly recommend that you contact your insurance company directly to obtain your insurance benefit information, as it is your responsibility to know and understand your own insurance benefits. You can find a Benefit Verification Form attached that will help you through this process. Please Initial____________

While we track the number of physical therapy visits used by each of our patients, **the patient him/herself is ultimately responsible for keeping track of his/her own visits**. Please be aware of the number of physical therapy visits your insurance policy awards you, **and keep track of the number of visits remaining as you use them.** Pace Physical Therapy is not responsible for tracking any visits to other providers, which should be taken into account by you when tracking your own visits**.** Please Initial____________

Self Pay

Kindly pay the balance in full at the time of service. Please be advised that failure to maintain this arrangement may result in the placement of your account with a collection agency or attorney for collection. Please Initial____________

Workers' Comp

We will bill your Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all your charges if your carrier denies coverage. Please Initial___________

Cancellation and Attendance Policy

Appointments are made at designated time slots. If you are **late**, you will be seen for the remaining of your designated time slot. The fee for the late visit will remain the same as that of the originally designated time slot.
Please Initial____________

Please call the office 24hrs in advance of the scheduled appointment time to cancel or reschedule your visit. Monday appointments should be cancelled or rescheduled by leaving a message on the office phone no later than Sunday afternoon. This allows other patients in need of physical therapy to be accommodated. You are allowed ONE (1) late-cancellation (less than 24hrs notice) without incurring any penalties**. Thereafter, patients will be charged for the full balance for the session when cancelling with less than 24hrs notice**. Payment is due on your next scheduled visit. Please Initial____________

Please be advised that **any No-Shows (missing an appointment without advanced cancelation**) will result in the full balance for the visit to be charged to you**.** Payment is due on you next scheduled visit. Please Initial____________

Release of Medical Records

I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of medical information, by any means of communication, to Pace Physical TherapY, for the purpose of my physical therapy treatment. Please Initial____________

Copying Policy

There is no charge for copying up to 10 pages. There is a U$ 10.00 for copying your medical records, Copying will be U$ 0.50 per page after the minimum fee. You agree to pay this fee should you need copies of your medical records for any purpose. You may also request a professional medical photocopy service to obtain copies of your chart at you own cost. If your file is in storage, there will be a minimum of U$ 25.00 for retrieval. Please Initial____________

Consent to Treatment

I understand that I have been referred for rehabilitation treatment to Pace Physical Therapy. Pace Physical Therapy will design a plan care to meet my individual needs and preferences. I understand that I have the right to ask and have any questions answered prior to receiving treatment. This includes any risks or alternatives to the plan of care that has been prescribed for me. By signing, I consent to have Pace Physical Therapy provide treatment under the direction prescribed by my referring physician, dentist, podiatrist and/or by my therapist. This consent is intended as a waiver of liability for such treatment except for acts of negligence. Please Initial____________

Notice Of Privacy Practice

I acknowledge that I have been provided with a copy of the "Notice of Information Practices" by Pace Physical Therapy
Please Initial____________

My signature below signifies that I ____ have read, understood and accepted the terms of Pace Physical Therapy Office and Payments Polices:

______________________________	__________	____________________
Patient/Guardian Signature	Initials	Date Signed

Pace Physical Therapy

Prescription Request Form

Patient:_______________________________________ DOB:___________________________

If your insurance carrier states that your Physical Therapy Benefits are based on Medical Necessity, you will be required to provide our office with a medical referral (prescription/doctor's orders) from your referring doctor as often as it is required by state laws or by your insurance company. It is your responsibility to obtain a referral from your doctor whenever necessary**. We strongly recommend that you contact you referring doctor every 30 days to request a renewal of your physical therapy referral.**

In the event that there is a delay in obtaining the referral, you may do **one** of the following **(please check one):**

——— Delay therapy until the new referral is obtained. Contact your therapist as soon as the prescription is obtained in order to proceed with your therapy as soon as possible.

OR

_______ Continue with physical therapy without interruption (please be aware that in the event of an audit, the insurance carrier may deny payment for any visits that were pending a referral)

I have read and understood all of the above. I will contact my physician and obtain a new prescription every 30 days in order for my insurance carrier to continue paying for my therapy.

____ ________________________
Patient's signature Date

Pace Physical Therapy Medical History Form

Please be as detailed as possible

Name: ____ Age: ______________ Date: ____________________

Date of onset, injury, or surgery: ____

Is this injury the result of a fall? (When? Where?) ____

Have you had a fall in the last year?______________ Have you had two or more falls in the last year? ______________

Please describe all areas of symptoms, and describe symptoms: ____
____
____
____
____

Have you had treatment for this condition before? Please explain: ____
____
____
____

Are you experiencing any of the following:

Loss of Bladder control _____ Loss of Bowel control ______ Dizziness /Faintness/Vertigo_________

Any known results of recent X-rays, MRI, CAT Scan or other tests: ____
____

List Surgeries and dates: ____
____

List any medications you are taking **AND dosage**. Please be detailed, you may use the back of this form or print a list of your own if more space is needed:

Name: _______________ Dosage______________ Reason: __________________ Orally Injection Cream (Circle one)
Name: _______________ Dosage______________ Reason: __________________ Orally Injection Cream (Circle one)
Name: _______________ Dosage______________ Reason: __________________ Orally Injection Cream (Circle one)
Name: _______________ Dosage______________ Reason: __________________ Orally Injection Cream (Circle one)
Name: _______________ Dosage______________ Reason: __________________ Orally Injection Cream (Circle one)

Do you have or had any of the following?

Allergies______
Anemia ______
Anxiety______
Arthritis______
Asthma______
Cancer______
Cardiac Conditions______
Cardiac Pacemaker______
Chemical Dependency______
Circulation Problems______
Currently Pregnant______

Depression______
Diabetes______
Dizzy Spells______
Emphysema/Bronchitis______
Fractures______
Gallbladder Problems______
Hepatitis______
High Blood Pressure______
Incontinence______
Kidney Problems______
Metal Implants______

Multiple Sclerosis______
Osteoporosis______
Parkinsons______
Rheumatoid Arthritis______
Seizures______
Speech Problems______
Strokes______
Thyroid Disease______
Tuberculosis______
Vision Problems______
Other: ______________________

How would you rate your level of pain?

Current: 0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Severe pain

At its best: 0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Severe pain

At its worst: 0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Severe pain

Please describe your pain(s) (i.e. dull, stabbing, burning, sharp, etc) ____
____
____

What activities or positions make your symptoms worse? ____
____
____

What makes your symptoms better? ____
____

Anything else you think we should know about you? ____
____
____

Patient Signature____Date: ______________________________

Pace Physical Therapy

HIPPA Contact Information,
Limited Authorization and Release Form

May we leave a message regarding your appointment, and/or billing (please circle the answer)

Answering Machine	Yes	No
Cell voice mail:	Yes	No
Email	Yes	No
Cell Phone message	Yes	No
Text	Yes	No

May we leave a message discussing medical information: (please circle one)

Answering Machine	Yes	No
Cell voice mail:	Yes	No
Email	Yes	No
Cell Phone message	Yes	No
Text	Yes	No

Please list any other parties that can have access to your health information:

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

In signing this HIPAA Patient Acknowledgement Form you acknowledge and authorize that this office may recommend products or services to promote you improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under HIPAA Omnibus Rule provide you this information with your knowledge and consent.

Signature__________________________________ Date______________________

Pace Physical Therapy

Pace Physical Therapy accepts all PPO plans with OUT-OF-NETWORK benefits. **We do not accept assignment of benefits on insurance claims**.

We will verify your benefits *as a courtesy to you.* Benefit information given to us by insurance companies is sometimes erroneous and inaccurate. We URGE you to call your insurance company for complete details on your benefits regarding physical therapy, including both covered and non-covered services.. **You are financially responsible for any payments not covered by your insurance.**

For accurate information call the "toll-free" number on the back of your insurance card. Make sure you speak to a representative**. DO NOT use the automated system**. Tell the representative that Pace Physical Therapy is an Outpatient Physical Therapy Office (privately owned).

Ask for the following information:

Name of the person you are speaking with: ________________________________ Date:_______________________

Reference # of call (if available): ____

1. How much is my deductible for outpatient, out-of-network, physical therapy? $_____________ Amt Met? ________
2. Do I have a co-pay each date of service? Y / N How much? $____
3. What is my co-insurance percentage? (i.e 40%, 50%, 20%) ____
4. Does my policy requires pre-authorization for physical therapy services? Y/ N
If yes, what needs to be done? ____
5. How many physical Therapy visits do I have per year? ____________ How many have I already used? ___________
6. Is there a maximum dollar amount that my plan pays for physical therapy? Y / N
If yes, how much is the maximum amount? $_________________ How much already used? $______________________
7.For secondary insurances (i.e. UHC, AETNA, etc..). Does my out-of-pocket needs to be met before paying? Y /N
If yes: What is my out-of-pocket amount? $________________________ Met? $________________________________
8. Are there any Physical Therapy services that are not covered by my plan?___________________________________

I, ________________________________, understand that Pace Physical Therapy does not accept assignment on insurance claims. I understand that I am responsible for paying the full balance of the session at the time of service. I understand that, as a courtesy to me, Pace Physical Therapy will bill my insurance company on my behalf, and my insurance company will send any payments to me directly. I am aware that VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT FROM MY INSURANCE COMPANY.

PLEASE CHOOSE ONE OF THE OPTIONS BELOW:

I, _________________________________, have called my insurance company to verify my benefits. I understand that I am responsible for obtaining accurate information about my insurance benefits so that Pace Physical Therapy can bill on my behalf. I am aware that VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT FROM MY INSURANCE COMPANY.

OR

I, ________________________________, choose not to call my insurance directly and accept the information provided as a COURTESY to me by Pace Physical Therapy regarding my insurance benefits. I understand that while Pace Physical Therapy has taken all reasonable actions to provide me with accurate information, VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT FROM MY INSURANCE COMPANY. By choosing not to verify my own benefits personally, I exempt Pace Physical Therapy from any responsibility regarding erroneous benefit information.

Patient Signature: ____ Date: __________________