Suncare Therapy, Inc.
Clinical Services Group

Patient Information Sheet.

Please fill in the required information and provide us with your ID and insurance card for us to make a copy.

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____ Cell: _____
Where do you work? _____ Position: _____
Address: _____ City/ ST/ Zip: _____
Social Security Number: _____ Sex: M F Marital Status: M S W
E-Mail Address: _____
Who can we notify in case of emergency? _____
Relation to patient: _____ Phone Number: _____
How did you hear from us?
Past Patient Friend Doctor Internet Insurance Company Other
Who is your referring Physician? _____

INSURANCE INFORMATION

Name of Primary Insurance Company: _____
ID #: _____ Group #: _____ Phone #: _____

Name of Secondary Insurance Company: _____
ID #: _____ Group #: _____ Phone #: _____

Is your injury related to a work Accident? YES NO Date of Accident:
_____
Is your injury related to an Auto Accident? YES NO Date of Accident:
_____
Are you being represented by an Attorney? YES NO
Attorney Name, Address and Phone #: _____

Patient Signature: _____ **Date:** _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

Suncare Therapy, Inc.
Clinical Services Group

MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

DO YOU HAVE ANY HYSTORY OF THE FOLLOWING? PLEASE CHECK YES OR NO
TIENE USTED HISTORIAL MEDICO DE ALGUNA DE ESTAS CONDICIONES? POR FAVOR MARQUE SI O NO

Y N ORTHOPEDICS

- ❑ ❑ Degen. Joint Disease (Desgaste De La S Coyuntutrs
- ❑ ❑ Hip Dislocation (Dislocacion De Cadera)
- ❑ ❑ Metal Implants (Implantes De Metal)
- ❑ ❑ Hip Fractures (Fractura De Cadera)
- ❑ ❑ Osteomyelitis (Osteomyelitis)
- ❑ ❑ Rotator Cuff Tear/Repair (Cirugia Del Hombro)
- ❑ ❑ Shoulder Dislocation (Dislocacion De Hombro)
- ❑ ❑ Scoliosis (Scoliosis)
- ❑ ❑ Gout (Gota)
- ❑ ❑ Osteoporosis (Osteoporosis)
- ❑ ❑ Arthritis (Artritis)
- ❑ ❑ Herniated Disc (Disco Herniado)
- ❑ ❑ Back Fusion (Fusion De La Columna)
- ❑ ❑ Foot Problems (Problemas En Los Pies)
- ❑ ❑ Finger, Joint, Hand Problems (Problemas En Las Manos
- ❑ ❑ Artificial Limbs (Ext. Artificiales/ Protesis)

Y N Cerebrovascular

- ❑ ❑ Stroke (Derrame Cerebral)
- ❑ ❑ R Or L Side Weakness (Debilidad Izq O Der)
- ❑ ❑ R Or L Side Paralysis (Paralisis Izq O Der)
- ❑ ❑ Difficulty With Speech (Dificultad Al Hablar)
- ❑ ❑ Difficulty Swallowing (Dificultad Al Tragar)
- ❑ ❑ Blurred Vision (Vision Borrosa)
- ❑ ❑ Headaches (Dolores De Cabeza)
- ❑ ❑ Epilepsy (Epilepsia)
- ❑ ❑ Seizures (Convulsiones)
- ❑ ❑ Parkinson Disease (Enfermedad De Parkinson)
- ❑ ❑ Poor Balance (Falta De Equilibrio)

Y N Cardiovascular

- ❑ ❑ Heart Attack/ Mi (Ataque Cardiaco)
- ❑ ❑ Congestive Heart Failure (Conjestion Del Corazon)
- ❑ ❑ High Blood Pressure (Pression Alta)
- ❑ ❑ Angina/ Chest Pain (Dolor En El Pecho)
- ❑ ❑ Dizziness (Mareos)
- ❑ ❑ Weakness (Debilidad)
- ❑ ❑ Pacemaker (Marcapaso)
- ❑ ❑ Irregular Heart Beat (Palpitaciones Irregulares)
- ❑ ❑ Peripheral Vascular (Problemas Vasculares)
- ❑ ❑ High Cholesterol (Colesterol Alto)

Patient Signature: (Firma Del Paciente)

_____

Y N RESPIRATORY

- ❑ ❑ Shortness Of Breath / (Falta De Aire)
- ❑ ❑ Asthma (Asma)
- ❑ ❑ Bronchitis (Bronquitis)
- ❑ ❑ Emphysema (Emphysema)
- ❑ ❑ Pneumonia (Neumonia)
- ❑ ❑ Tuberculosis (Tuberculosis)
- ❑ ❑ Persistent Dry Cough (Toz Seca)
- ❑ ❑ Productive Cough (Toz Con Flema)
- ❑ ❑ Bloody Sputum (Flema Con Sangre)

Y N Health Profile

- ❑ ❑ Smoke (Fuma?)
- ❑ ❑ Drink Alcohol (Consume Alcohol)
- ❑ ❑ Exercise Regularly (Ejercita Regularmente)
- ❑ ❑ Feel Tired Often (Cansancio Frequente)

Y N Urinary Tract

- ❑ ❑ Painful Urination (Dolor Al Orinar)
- ❑ ❑ Incontinence (Incontinencia)
- ❑ ❑ Kidney Stones(Piedras En Los Riñones)
- ❑ ❑ Frequent Urination (Orina Frecuentemente)
- ❑ ❑ Bladder Infection (Infeccion En La Vejiga)

Y N Lymphedema

- ❑ ❑ Swollen Legs (Inflamacion En Las Piernas)
- ❑ ❑ Mastestomy R Or L (Mastectomis Der O Izq)
- ❑ ❑ Radiation (Radiacion)
- ❑ ❑ Open Sores (Yagas Abiertas)

Y N Immune System

- ❑ ❑ Rheumathoid Arthritis (Artritis)
- ❑ ❑ Lupus (Lupus)
- ❑ ❑ Multiple Sclerosis (Esclerosis Multiple)
- ❑ ❑ Hiv/Aids (Vih/ Sida)
- ❑ ❑ Hepatitis (Hepatitis)
- ❑ ❑ Liver Disease (Enfermedad Del Higado)
- ❑ ❑ Cancer (Cancer)
- ❑ ❑ Diabetes (Diabetes)
- ❑ ❑ Peripheral Neuropathy(Neuropatia)
- ❑ ❑ Thyroid Disease (Enfermedad De La Tiroide)

Y N Gastroenterology

- ❑ ❑ Stomach Ulcers (Ulceras Estomacales)
- ❑ ❑ Hiatal Hernia (Hernia Hiatal)
- ❑ ❑ Diarrhea (Diarrea)
- ❑ ❑ Bloating (Inflamacion El Vientre)
- ❑ ❑ Incontinence (Incontinencia)

Suncare Therapy, Inc.
Clinical Services Group

PATIENT NAME: _____ DOB: _____

ASSIGNMENT OF BENEFITS:

I hereby assign, transfer and set over to Suncare Physical Therapy all of my rights, title and interest to my medical reimbursement under my insurance policies. To make check payable of direct deposit to Suncare Physical Therapy 5803 NW 151 Street #101, Miami Lakes, Fl 33014. If my current policy prohibits direct payment to Suncare Physical Therapy, I hereby assign my insurance to make the check payable to me (the patient) and mail it to the above mentioned address. I will the assign over payment of these funds to Suncare to assist in the settlement of my account. I understand it is a crime to provide false information in order to receive payment from any insurance company. I will notify you of any changes in my insurance information.

INITIALS: _____

PAYMENT AGREEMENT:

My estimated payment of $_____ is due at each visit. I understand that this estimated payment has been established to go towards my deductible / out of pocket of $ _____. Once my deductible has been met, my insurance pays at _____%. At the end of my therapy, I understand that I am responsible for all charges until my deductible has been met at which time I will be responsible for _____ of the charges.

I understand that the above benefits are based on information provided by my insurance carrier. Suncare Therapy cannot guarantee that my claims will be processed as stated above. It is my responsibility to review my explanation of benefits when received and call my insurance carrier if I feel there are any errors. My final balance will be determined when my claims are processed.

I understand that with **Worker's Compensation**, Suncare Therapy nor any institution, is able to pursue the individual for the remaining balance on the account. However, if false information is intentionally provided, the patient may be liable for any / all charges on this account.

INITIALS: _____

RELEASE OF INFORMATION:

I authorize the release of any requested records for review, by authorized representatives of Medicare, my insurance company, and my physician of provider. I authorize the review of these records for any audits within the agency. This information shall also serve as a release from any legal liability that that may arise from the release of these records. I authorize the release of any necessary information from my provider, if requested and related to my treatment at Suncare.

INITIALS: _____

CONSENT TO TREAT:

I hereby the staff at Suncare therapy to administer, perform and carryout all procedures as prescribed by my provider, I will notify you of any changes in my health status.

INITIALS: _____

PERSONAL VALUABLES:

I understand that Suncare Therapy will not be liable for any loss or damage to any money, jewelry, documents and other articles of value that I choose to bring to the center.

INITIALS: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

MEDICAL RECORDS RELEASE

PATIENT NAME: _____CHART#: _____
SS#: _____ DOB: _____

I, THE UNDERSIGNED AUTHORIZE _____ TO RELEASE COPIES OF ALL NECESSARY MEDICAL RECORDS TO SUNCARE PHYSICAL THERAPY, I WAIVE ALL RESPONSIBILITY REGARDING THE CONFIDENTIALITY OF SAID MEDICAL RECORDS OR PHOTOCOPIES RELEASED TO THE AFOREMENTIONED PARTY.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

TO: _____ DATE FAXED: _____
ATTN: MEDICAL RECORDS DEPT FAX#: _____

PLEASE PROVIDE US WITH ALL MEDICAL RECORDS FOR THE ABOVE MENTIONED PATIENT AND DATE OF SERVICE.

PLEASE FAX TO: 305-231-5264
OR MAIL TO: 5803 N.W. 151 Street #101
MIAMI LAKES, FL 33014

THANK YOU,

_____

YOUR **HIPAA** RIGHTS AND RESPONSIBILITIES
NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION:

At SUNCARE PHHYSICAL THERAPY, INC we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective October 21, 2002, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit SUNCARE PHYSICAL THERAPY a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- ☑ Basis for planning your care and treatment.
- ☑ Means of communication among the many health professionals who contribute to your care.
- ☑ Legal document describing the care you received.
- ☑ Means by which you or a third-party payer can verify that services billed were actually provided.
- ☑ A tool in educating health professionals.
- ☑ A source of data for medical research.
- ☑ A source of information for public health officials charged with improving the health of this state and the nation.
- ☑ A source of data for our planning and marketing.
- ☑ A tool with which we can assess and continually work to improve the care we render and the outcome we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, when, what, where and why access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Although your health record is the physical property of SUNCARE PHYSICAL THERAPY, the information belongs to you. You have the right to:

- ☑ obtain a paper copy or the Notice of Information Practices upon request
- ☑ inspect and copy your health record as provided for in 45CFR 164.524
- ☑ amend your health record as provided for in 45 CFR 164.528
- ☑ obtain an accounting of disclosures of your health information as provided in 45 CFR 165.528
- ☑ request communications of your health information by alternative means or at alternative locations.
- ☑ Request a restriction on certain uses and disclosures of your information as provides by in 45 CFR 164.522
- ☑ Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: SUNCARE PHYSICAL THERAPY, INC. is required to:

- ☑ Maintain the privacy of your health information.
- ☑ Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- ☑ Abide by the terms of this notice.
- ☑ Notify you if we are unable to agree to a requested restriction.
- ☑ Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our Practices and to make the new provisions effective for all protected health information we maintain. Should our information Practices change, we will mail a revised notice to the address you have supplied us, or if you agree we will E-mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as describes in this notice, we will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions and would like additional information, you may contact SUNCARE PHYSICAL THERAPY, INC. privacy officer **ASTRID ARRIETA** at **305-231-5266.**

If you believe your privacy rights have been violated, you can file a complaint with SUNCARE PHYSICAL THERAPY, INC. privacy officer or with the Office for Civil Rights, U. S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the privacy officer or the Office for Civil Rights. The address for the OCR is listed below:

OFFICE FOR CIVIL RIGHTS
US DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVENUE S.W. ROOM 509F, HHH BUILDING WASHINGTON, DC 20201

ACKNOWLEDGEMENT OF HIPAA RIGHTS AND RESPONSIBILITIES:

I acknowledge and understand the notice of helath information practices that i have received from suncate physical therapy, inc. Containing information on understanding my health record and information, my health information rights and other responsibilities.

I have read the statement given to me and understand it completely.

_____	_____	_____
PATIENT'S NAME	**PATIENT'S SIGNATURE**	**DATE:**