



• THERAPY • PERFORMANCE • WELLNESS

DESCRIPTION

SPINE & SPORT is a specialty practice that offers the very best in the physical therapy, massage therapy and performance training. This pioneering multidisciplinary concept represents a new and exciting approach to nonoperative and perioperative care, post-rehabilitation performance training and wellness.

SPINE & SPORT is a private medical and exercise studio located on the first floor of the Abacoa Professional Center II. The accommodations are designed specifically for those who desire to achieve their fullest potential but require special and caring consideration of their medical limitations. The studio is staffed with nationally recognized medical and exercise specialists and is equipped with state of the art performance and wellness training equipment.

SERVICES

Comprehensive Physical Therapy: Nationally recognized physical therapists specializing in nonoperative and perioperative care evaluate and treat patients through an evidence-based approach. All treatment is rendered on a one-on-one basis and with specific attention to individual needs.

Comprehensive Massage Therapy: Licensed massage therapists provide a range of modalities including Trigger Point Myotherapy, Swedish, Deep Tissue and Perinatal massage. These procedures can be utilized on a stand alone basis or in conjunction with other services. Lic # MA30667

Comprehensive One-On-One Movement & Performance Training: This service encompasses post-rehabilitation wellness training, preventative conditioning, preoperative preparation and sport performance enhancement. Sessions are conducted on a one-on-one basis with a spine therapist or performance trainer. Spine & Sport is registered with the State of Florida as a Health Studio. Registration No. HS7717.

DIRECTIONS

Conveniently located in the beautiful community of Abacoa near I-95 and Alternate A1A.

Traveling North: Take Military Trail north bound to University Blvd. make a U Turn. You will now be traveling south on Military Trail. Make your second right at Heritage Drive. We are the second building on your left, #600.

Traveling South: Take Military Trail south bound. Heritage Drive is the second right after you pass through the University Blvd. light. We are the second building on your left, #600.

HOURS OF OPERATION

Monday - Friday: 7:00 AM - 7:00 PM

Saturday: 8:00 AM - 12:00 PM

Extended hours available upon request



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PERSONAL PROFILE

NAME: _____ DATE: ____ / ____ / ____

LOCAL ADDRESS: _____

LOCAL PHONE: _____ CELL: _____

FAX NUMBER: _____ WORK: _____

EMAIL ADDRESS: _____

ALTERNATE ADDRESS: _____

ALTERNATE PHONE: _____ FAX: _____

OCCUPATION: _____

REFERRED BY: _____

FAMILY PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

YOUR MARITAL STATUS: _____ YOUR BIRTH DATE: ____ / ____ / ____

AGE: _____ YRS HEIGHT: _____ FT WEIGHT: _____ LBS

MEDICATIONS: _____

MEDICAL HISTORY: _____

CONCERNS: _____

GOALS: _____

SPINE & SPORT

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HEALTH HISTORY

NAME: _____ DATE: _____ / _____ / _____

PLEASE CIRCLE "Y" FOR YES OR "N" FOR NO AND FILL-IN THE BLANKS AS NECESSARY. THANK YOU.

1. (Y / N) DO YOU SMOKE? IF YES, HOW MANY PACKS PER DAY? _____
(Y / N) ARE YOU TRYING TO QUIT? IF YES, WHAT METHOD ARE YOU USING? _____
2. (Y / N) HAS YOUR DOCTOR EVER TOLD YOU THAT YOUR BLOOD PRESSURE WAS TOO HIGH?
(Y / N) HAS YOUR DOCTOR EVER TOLD YOU THAT YOUR BLOOD PRESSURE WAS TOO LOW?
3. (Y / N) HAVE YOU, OR A CLOSE FAMILY MEMBER, EVER BEEN DIAGNOSED WITH DIABETES?
4. (Y / N) DO YOU HAVE ANY KNOWN CARDIOVASCULAR PROBLEMS (ABNORMAL ECG, PREVIOUS HEART ATTACK, ATHEROSCLEROSIS, ETC.)? IF YES, PLEASE INDICATE. _____
5. (Y / N) HAS YOUR DOCTOR EVER TOLD YOU YOUR CHOLESTEROL LEVEL WAS HIGH?
IF YES, PLEASE INDICATE THE TOTAL NUMBER AND RATIO. _____
6. (Y / N) ARE YOU CURRENTLY OVERWEIGHT? IF YES, PLEASE INDICATE HOW MUCH. _____
7. (Y / N) DO YOU HAVE ANY PAST OR CURRENT INJURIES OR ORTHOPEDIC PROBLEMS (BURSITIS, KNEE INJURY, SPINE PROBLEMS, ETC.)? IF YES, PLEASE INDICATE. _____

8. (Y / N) ARE YOU PREGNANT OR POST-PARTUM LESS THAN SIX WEEKS?
9. (Y / N) HAVE YOU HAD A RECENT PHYSICAL EXAM? PLEASE INDICATE THE DATE: ____ / ____ / ____
10. (Y / N) HAS YOUR DOCTOR EVER TOLD YOU THAT YOU HAVE A HEART CONDITION AND SHOULD ONLY PERFORM PHYSICAL ACTIVITY RECOMMENDED BY A PHYSICIAN?
11. (Y / N) HAVE YOU EVER HAD CHEST PAIN WHILE NOT ENGAGING IN PHYSICAL ACTIVITY?
12. (Y / N) DO YOU LOSE YOUR BALANCE DUE TO DIZZINESS OR DO YOU EVER LOSE CONSCIOUSNESS?
13. (Y / N) DO YOU HAVE A BONE OR JOINT PROBLEM THAT COULD BE MADE WORSE BY A CHANGE IN YOUR PHYSICAL ACTIVITY?
14. (Y / N) IS YOUR DOCTOR CURRENTLY PRESCRIBING DRUGS (EX. WATER PILLS) FOR YOUR BLOOD PRESSURE OR HEART CONDITION? IF YES, PLEASE INDICATE. _____
15. (Y / N) DO YOU KNOW OF ANY OTHER REASON WHY YOU SHOULD NOT ENGAGE IN PHYSICAL ACTIVITY? IF YES, PLEASE INDICATE. _____

16. PLEASE REVIEW THE LIST OF CONDITIONS BELOW AND CHECK ALL THAT APPLY TO YOU.

- | | | |
|---|---|--|
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> CANCER | <input type="checkbox"/> BLADDER DIFFICULTIES |
| <input type="checkbox"/> HEART PALPITATIONS | <input type="checkbox"/> SEIZURES OR EPILEPSY | <input type="checkbox"/> INFECTIONS |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> DIFFICULTY WALKING | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> DIZZINESS OR BLACKOUTS | <input type="checkbox"/> JOINT PAIN OR SWELLING | <input type="checkbox"/> AREAS OF SWELLING |
| <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> PAIN AT NIGHT | <input type="checkbox"/> WEIGHT LOSS OR GAIN |
| <input type="checkbox"/> COORDINATION PROBLEM | <input type="checkbox"/> DIFFICULTY SLEEPING | <input type="checkbox"/> UNEXPLAINED PAIN |
| <input type="checkbox"/> WEAKNESS | <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> FEVER, CHILLS OR SWEATS |
| <input type="checkbox"/> FRACTURES | <input type="checkbox"/> NAUSEA OR VOMITING | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> DIFFICULTY SWALLOWING | <input type="checkbox"/> HEARING PROBLEMS |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> BOWEL DIFFICULTIES | <input type="checkbox"/> VISION PROBLEM |

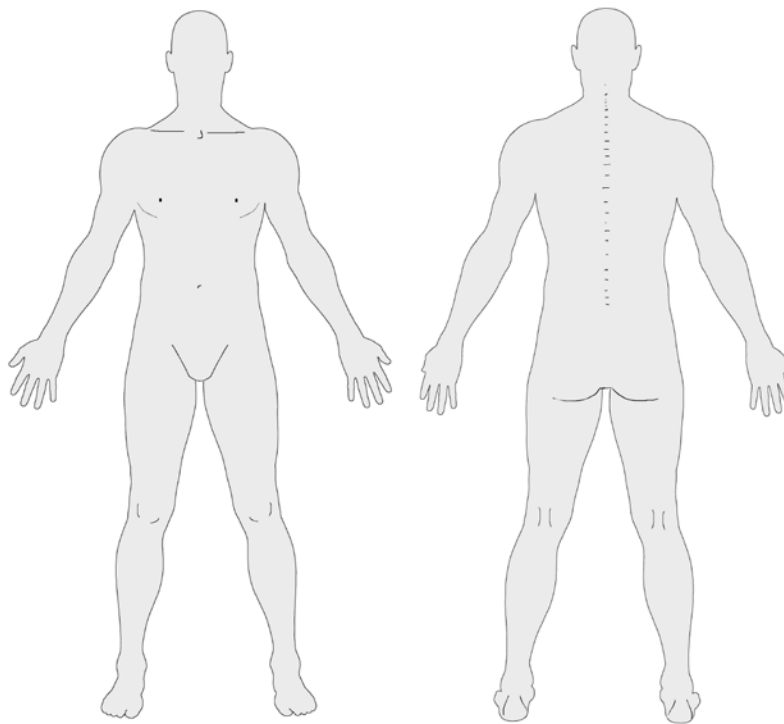
Other _____

Name: _____ Date: ____/____/____

Please use the drawings below to indicate where you are experiencing symptoms NOW.

Use the following key to indicate different types of symptoms:

Ache = **ZZZ** Stabbing = **XXX** Burning = **///////** Pins/Needles = **OOO** Stiffness = **^^^^**



Please indicate the intensity of your symptoms over the past 24 hours on the scales below:

RATE THE INTENSITY OF YOUR SYMPTOMS

0 = No Pain

Excruciating Pain = 10

WORST IN THE PAST 24 HOURS

0 1 2 3 4 5 6 7 8 9 10

LEAST IN THE PAST 24 HOURS

0 1 2 3 4 5 6 7 8 9 10



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INFORMED CONSENT

I, _____, hereby consent to voluntarily engage in a physical therapy and wellness training program recommended for the improvement of my general health, well-being and quality of life. I understand the intent of the program will be to provide rehabilitation, post-rehabilitation, fitness training, preventative conditioning and/or sport performance enhancement.

In order to determine my physical capacity to participate in an individualized goal-specific physical therapy and wellness program, I acknowledge that a comprehensive examination is required. The exam will require full disclosure of my present medical condition, past medical history, and a physical assessment. Physical assessment procedures will include an examination of my posture, range of motion, joint mobility, muscle flexibility, muscle strength, neurovascular status, and balance/coordination. I understand that I may be required to receive a physician's clearance to participate in an individualized physical therapy and wellness program *if* the evaluating therapist deems it necessary after the initial examination. I consent to these procedures and agree, if necessary, to acquire a physicians approval to participate in the physical therapy and wellness training program.

I understand that each session may include manual procedures to enhance my joint range of motion, muscle flexibility, muscle tone, muscle coordination, balance and functional/sport related movement patterns. In addition, I will engage in exercises which may include aerobic activities (treadmill, stationary bicycle, elliptical trainer, stair climber, upper body ergometer, running, circuit training, etc...), isometrics, plyometrics, resistance training, Pilates exercises, Gyrotonic® exercises, balance training, Fit-ball exercises, medicine ball activities, and other supervised and unsupervised activities to improve my overall health, muscle strength, range of motion, muscle flexibility and capacity to engage in sport activities. I voluntarily consent to these passive and active procedures.

I understand that this program may benefit my physical fitness or general health. However, the program cannot guarantee any particular level of improvement. I recognize that involvement in physical therapy and wellness training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment, and regulate physical effort.

I understand and have been informed that there exists the risk of bodily injury during the physical therapy sessions including, but not limited to, injuries to muscles/tendons, ligament, joints and periarticular structures, and adverse responses such as abnormal blood pressure changes, light headedness, fainting, dizziness, abnormal heart rate changes and, in rare instances, heart attack, stroke, or death. Additionally, I understand that by not providing all medically related information to the owners, operators, agents, employees, therapists, and instructors of Spine and Sport that I may be placing myself at an increased risk of serious injury and/or death. I fully understand and accept the risks associated with exercise and it is my desire to participate herein as indicated. I also understand that, at any time, it is my complete right to decrease or stop any procedure or activity and it is my obligation to inform the owners, operators, agents, employees, therapists, and instructors of Spine and Sport of any problems, adverse symptoms, and desires to discontinue participation.

I have been informed that the information obtained in this program will be treated as privileged and confidential and will not be released to any person without my express written consent except as required by law. I agree to the use of any information for the purpose of consultation with other health/wellness professionals, including my doctor. Any other information obtained, however, will only be used by the owners, operators, agents, employees, therapists, and instructors of Spine in the course of recommending interventions for me and evaluating my progress in the program.

I have been given the opportunity to ask questions as to the procedures of this program and, by my signature, I fully consent to participate in consideration of the aforementioned advisements.

PARTICIPANT _____ DATE _____

WITNESS _____ DATE _____



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PAYMENT POLICY

It is our policy that patients are directly responsible for their charges regardless of any insurance coverage including Medicare and/or supplemental insurance. Patients pay Spine & Sport directly at the time services are rendered and are reimbursed by their insurance company, Medicare and/or supplemental insurance. As required by law Medicare claims will be filed electronically. Office personnel will be happy to answer any questions you may have regarding the cost of our services. We accept cash, checks, VISA, MASTERCARD and AMERICAN EXPRESS.

Patient Signature _____ Date _____

For your convenience we will keep your credit card information on file and charge your account at the end of each session. Please supply us with the following information:

Name on Card _____ Type of Card _____

Credit Card Number _____ Expiration Date _____

I, _____, authorize Spine & Sport to charge the above referenced credit card account provided for services and/or goods provided to me as they are incurred.

Signature _____ Date _____

CANCELLATION POLICY

Our mission is to offer the highest quality medical care and wellness training. In striving to do so, we provide one-on-one attention and small group exercise classes. When an appointment is scheduled, we block off an entire hour for your care. Therefore, we can devote our full attention to your specific needs. If an appointment is cancelled with less than 24 hours notification and we are unable to secure another client for the time that you have reserved, then you will be responsible for the session fee.

Patient Signature _____ Date _____

INSURANCE POLICY

Our priority is the relationship we have with our patients. We focus on the medical needs of each individual without restrictions or influence from insurance companies. In this manner, we believe we are offering the very best in unbiased, evidence-based care. Many third party payers will reimburse a portion or all of your medical expenses. To assist you, we provide documents and forms so that you can independently submit claims to your carrier. In some cases we can submit these claims on your behalf. However, we cannot guarantee that your insurance company will reimburse you for services rendered through our office. We encourage you to contact your carrier for guidance or reimbursement eligibility.

Patient Signature _____ Date _____



RELEASE OF INFORMATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain authorization before releasing written or verbal information regarding any patient. Please fill out the below form accordingly. We thank you for your help and understanding.

I, _____, authorize SPINE & SPORT and its staff to release information regarding my condition to the following people:

- 1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Patient Signature _____ Date _____

Note: Please include everyone's name that you are allowing for us to release information to including, but not limited to: spouse, child, physicians (other than referring), relatives or friends. If the name is not listed above, we are unable to speak to or release information to them.

MEDICARE

SPINE and SPORT accepts Medicare patients. We are a non-participating Medicare provider and, as such, we do not get paid directly by Medicare. We will submit your claim and Medicare will pay/reimburse you directly. We are subject to certain limitations. There is a cap on the amount Medicare may reimburse you for physical therapy services provided to you in a calendar year. Please advise us if you have already received physical therapy elsewhere this year. In accordance with Medicare Policy, please complete the attached Advance Beneficiary Notice Of Noncoverage (ABN).

Patient Signature _____ Date _____

LIFETIME MEDICARE PART B SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of Spine & Sport any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself.

Patient Signature _____ Date _____

Medicare Number _____

Patient Name: _____

Identification Number: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: Medicare does not always pay for everything, even some care that you or your health care provider have good reason to think you need. We feel you should be informed. Here is what you should know:

What may not be covered:	1. Medicare pays a maximum (or Cap) of \$1,860.00 for physical therapy and speech language pathology combined. The services you receive at Spine & Sport are covered by Medicare subject to the Cap limit. 2. Medicare will only reimburse for services that are deemed “medically necessary.” If you are not restricted in your functional abilities and if you are able to participate in recreational activities such as golf, Medicare may not reimburse for physical therapy services.
Reason Medicare May Not Pay:	Medicare will not pay for physical therapy and speech-language pathology services over \$1,860.00 in 2010. In addition, Medicare may not reimburse for care rendered after lapses in treatment unless medically justified.
Estimated Cost:	Any cost in excess of the \$1,860.00 Cap is your responsibility. You must advise us if you have already utilized physical therapy services this year. We will monitor our charges and keep you informed of where you stand with regard to the Cap while under our care.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below.

Options: Check only one box. We cannot choose a box for you.
<p><input type="checkbox"/> OPTION 1. I want to proceed with my treatment at Spine & Sport. I understand I will be required to pay Spine & Sport at the conclusion of each of my treatment sessions, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I can appeal to Medicare by following the directions on the MSN.</p> <p><input type="checkbox"/> OPTION 2. I want to proceed with my treatment at Spine & Sport, but do not bill Medicare. I will pay you at the conclusion of each of my treatment sessions as I am responsible for payment. I cannot appeal if Medicare is not billed.</p> <p><input type="checkbox"/> OPTION 3. I don't want to be treated at Spine & Sport. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.</p>

Additional Information: This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, please call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You will also receive a copy.

Signature: _____	Date: _____
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