Mejia Physical Therapy and Wellness, LLC
3729 Falcon Ridge Circle, Weston, FL 33331
Phone (954) 632-8535 Fax (954) 659-0584

Welcome to Mejia Physical Therapy and Wellness!

My name is Luis Mejia; I am the owner and treating physical therapist at Mejia Physical Therapy and Wellness. I'm thrilled that you have chosen us to help you along your road to recovery!

Here at Mejia Physical Therapy and Wellness, our team considers you a part of the family. We work hard to get you back to where you want to be, but we also have fun in the process, helping you enjoy your efforts to improve or restore your health.

We enjoy hearing your stories and/or feedback about your experience with us. So please let us know how we're doing!

Whether you're here for physical therapy, conditioning, or health and wellness, we're glad you chose Mejia Physical Therapy and Wellness. Please don't hesitate to contact us with any questions you may have during your treatment.

Sincerely,

Luis Mejia, MA, PT

Owner and Physical Therapist
Mejia Physical Therapy and Wellness, LLC
info@mejiapt.com

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Patient Information Sheet

Personal

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Age: _____ Sex: Male / Female Date of Birth: _____ Height: _____ Weight: _____

Referring Physician

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

NPI: _____ Next Appointment: _____

Insurance

Please check the appropriate type(s) of insurance you have.

MEDICARE ☐ COMMERCIAL ☐ PRIVATE PAY ☐

Primary Insurance Company: _____

Name of Insured: _____ Relationship: _____ Self _____ Spouse

Policy Identification #: _____ Group #: _____

Secondary Insurance Company: _____

Name of Insured: _____ Relationship: _____ Self _____ Spouse

Policy Identification #: _____ Group #: _____

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Pre-Exam Form Occupation_____ Are you working now? **Yes** **No**

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Where is your pain/problem? _____
2. Is it a little, medium or a lot (generally)? _____
3. What caused your pain/or problem? _____
4. Approximately, when did it start? ____/____/20_____
5. Have you ever had this pain/problem before? **Yes** **No**
6. In your understanding, what do you think will make you better? _____
7. How optimistic are you that you'll get better? (**circle one below**)

   Not at all……Mildly optimistic……Fairly……Very optimistic……..Extremely
8. What are some potential obstacles to you getting better?_____
9. Over the next 30-days how many hours per week will you commit to getting better? _____
10. What are you expecting from your Physical Therapy program?_____
11. On the scale below circle your worst pain level in the past couple of days:

    Mild ***Moderate*** ***Severe***

    0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
12. Are any of your normal everyday activities affected? **Yes** **No** (If yes, describe how below)
13. List all past surgeries with dates: (**see surgical history sheet**)
14. List all medical conditions you have or were told you have? (**see medical history sheet**)

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian):_____ Date: _____

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MEDICAL HISTORY								
	Y	**N**		**Y**	**N**		**Y**	**N**
High/Low Blood pressure			Parkinson's Disease			Macular Degeneration		
Coronary Artery Disease			Asthma			Osteoarthritis		
Aortic Aneurysm			Shortness of Breath			Rheumatoid Arthritis		
Peripheral Vascular Disease			Emphysema			Fibromyalgia		
Heart Attack			Cancer			Psoriasis/Eczema		
Arrhythmia			Kidney Disease			High Cholesterol		
Seizure Disorder			Urinary Tract/Disease			HIV/AIDS		
Stroke (CVA/TIA)			Prostate Disease			Osteoporosis/Osteopenia		
Neuropathy			GI Problems/Disease			Fractures		
Diabetes			Ulcer			Spinal Stenosis		
Hypoglycemia			Glaucoma			Degenerative Disc Disease		
Hypothyroidism/Hyperthyroidism			Liver Disease			Dis Herniation/Bulge		
Vertigo			Gall Bladder Disease			Hard of Hearing		
Balance Issues (Inner Ear)			Headaches (Migraine/Tension)			Difficulty seeing		

SURGICAL HISTORY								
	Y	**Date R / L**		**Y**	**Date**		**Y**	**Date**
Cervical Surgery			Pacemaker			Mastectomy R / L		
Lumbar Surgery			Cardiac Bypass			Breast Aug / Recon (R/L)		
Shoulder Surgery			Angioplasty			C=Section		
Elbow Surgery			Prostate			Ovarian		
Wrist Surgery			Bladder			Appendectomy		
Hand Surgery			Gall Bladder			Cataract R /L		
Hip Surgery			Bariatric			Eye- Other R /L		
Knee Surgery			Kidney			Thyroid		
Ankle Surgery			Liver			Ear R/L		
Foot Surgery			Gastrointestinal			Brain		

Medication Allergies: _____ **Other Allergies**: _____

_____ _____

Signature ***Date***

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Authorization to Release Medical Record Information

Mejia Physical Therapy and Wellness, LLC is hereby authorized to disclose all or any part of the medical record of the patient named in the registration to such insurance companies or agencies as may be concerned with the payment of professional and/or facility costs of the patient named in this registration. The authorization is effective for three years from the date of service and may be revoked with written notification.

Consent to Receive Medical Care

The undersigned hereby consents to any therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of Mejia Physical Therapy and Wellness, LLC as to the results of any treatment performed.

Medicare

Mejia Physical Therapy and Wellness, LLC accepts Medicare. This means that we will accept the Medicare approved amount as payment in full for our services. We will bill Medicare and your supplemental insurance company as a courtesy to you. Medicare will pay 80% directly to us and the other 20% must be collected from the patient or from your supplemental insurance company. If your supplemental insurance company does not pay or if your Medicare deductible has not been met, you will receive a statement from us indicating the amount you owe.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. ***By my signature below, I recognize, understand and accept that I am ultimately financially responsible for any and all charges for services rendered.***

Attendance Policy

It is the patient's responsibility to make and confirm their appointments (date/time). We are unable to guarantee standing appointments, but will make every effort to schedule appropriately so that a patient never has an extended wait to see a therapist. If you are unable to attend an appointment, we ask that you call 24 hrs from your scheduled appointment time in advance to let us know. By calling us, you will allow us to make the appropriate changes to the schedule to benefit all patients. ***A $60 cancelation fee will be charged for missed appointments without 24 hr notice.***

Medical Emergencies

In the event of a medical emergency, it is our policy to call 911. I understand that any Mejia Physical Therapy and Wellness, LLC staff has the authority to prevent me from further participation because of injury, illness and/or any undue liability to Mejia Physical Therapy and Wellness, LLC.

I certify that I have read and understand fully the above information.

_____ _____

Signature of Patient/Guardian Print Name Date

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Mejia Physical Therapy and Wellness, LLC
ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the **Mejia Physical Therapy and Wellness, LLC** Patient Notice of Privacy Practices effective 1/1/2017.

Date: _____ Patient Signature: _____
(or Guardian, if applicable)

Please submit all requests in writing to our Medical Records Department, at Mejia Physical Therapy and Wellness, LLC 3729 Falcon Ridge Cir, Weston, FL 33331 (Attn: Luis Mejia, MA, PT) There may be a charge for transferring medical records.

If you have any questions regarding this notice or the HIPAA privacy policies please contact Luis Mejia, MA, PT, privacy officer) at 954 632-8535 or through email at: luismejiapt@gmail.com.