Pilates in the Grove LLC
www.pilatesinthegrove.com info@pilatesinthegrove.com

Welcome to our practice! Please help us serve you better by taking a few minutes to provide the following information.

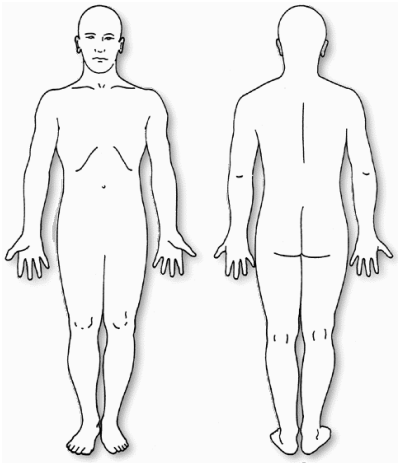
Name:	Last Name	First Name			Today's date:				
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Insurance Provider:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit						
Specialist Physician	Name:		Date of next visit						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
When and how did your symptom(s) begin? (Date):
For Office Use ONLY:
Recommended Frequency: Recommended Duration: Recommended practitioner: Re-Evaluation Date: Additional Notes: Signature: Send POC: Y N

Please shade in areas where you have pain, discomfort, or tension.



3316 Virginia Street, Coconut Grove, FL 33133 • (305) 446-6899
5900 SW 73rd Street, Suite #104, South Miami, FL 33143 • (305) 397-8308

Please rate your pain on a scale of 1-10 for each category with 10 being worst and 1 being least:	At its worst	
	At its best	
	At present	

What does your pain keep you from doing?	
What activities decrease your pain?	

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

Is there a chance you may be pregnant at this time?	Yes	No

Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When

Informed Consent and Additional Policies

I understand that Pilates in the Grove LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. By initialing here I certify that I was provided with the full Privacy Policy _____

The state of Florida allows for direct access to Physical Therapy for 10 sessions or 30 consecutive days without a referral. If you require treatment beyond 30 days you will need to obtain a signed POC or prescription from a licensed MD or nurse practitioner. Your insurance carrier may request a prescription for any and all services. _____

If you cannot make your scheduled appointments please allow 24 hours notice for cancellations. Cancellations must be made by calling the office during normal business hours 8:00am-6:00pm Monday-Thursday, 8:00am-3:00pm Friday and 8:00am-12:00pm Saturdays. Cancellations made outside of these times will be subject to a cancellation fee or the full cost of the session for no-shows. _____

A valid credit card number must be provided when scheduling your appointments. The information is securely protected in your electronic medical record and will only be used should you fail to attend or late cancel an appointment. _____

I do hereby agree and give my consent for Pilates in the Grove LLC to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. _____

I have read and understand the payment policies. I understand insurance reimbursement is not guaranteed and that Pilates in the Grove does not deal directly with any insurance company. Payment is due at time of service. I will receive a superbill with all appropriate codes and payment information and I will be solely responsible for submitting any claims for reimbursement. I may be subject to additional administrative fees should additional documentation or administrative forms be requested. ____

I hereby certify that all the above information is true to the best of my knowledge and have read and understand the above policies with regards to my care.

Patient/Parent/Guardian Signature:_____

Date:_____