Welcome to Ocean Physical Therapy!

We would like to congratulate you on making the decision to take a proactive role in your health, as we feel that achievement of your physical goals involves the active pursuit of total wellness. Your health and well-being is more than just your injury, and physical therapy is just one part of your total rehabilitative process. Many patients will need more than physical therapy along the road to wellness, and we are here to provide that help. We offer a multidisciplinary approach to rehabilitation incorporating acupuncture, massage therapy, Pilates, and other disciplines into your comprehensive program addressing all the aspects of wellness to help you achieve your whole potential. By choosing Ocean Physical Therapy you are taking one step closer to overall health and wellness that will enable you to meet all your recreational, sport, work, and daily lifestyle goals.

Your physical therapy plan

Our mission is to combine multiple treatment techniques to achieve an integrative, whole solution to your challenges. During your rehabilitation process we will look to progress you from skilled hands-on manual therapy and therapeutic exercise, to functional strength training, to sport- and activity-specific training for life-long fitness. Your physical therapist will review your individualized plan of care, but most rehabilitation plans will include:

- 1-2 months (8-24 visits) of skilled rehabilitation, with goals of progressing to an independent or skillfully guided exercise routine for life long wellness
- 2-3 visits per week initially, with decreasing frequency as you make progress toward your goals
- 45-75 minutes long treatments, consisting of skilled manual treatment followed by instruction in specific medical exercise to re-educate and restore muscle balance

Our specially designed rehab & post-op programs

We provide specialized rehabilitation programs specific to your body ailment that include comprehensive assessment of your functional impairments and targeted treatment of your individual deficits. These include, but are not limited to:

- Rotator cuff repair
- ACL & meniscus repair
- Total joint reconstruction
- Degenerative disc disease of spine
- Herniated disc
- Ankle sprains
- Scoliosis
- Elbow tendinitis

We're not just physical therapy

We offer many integrative services and classes to supplement the progress you are making with physical therapy. These services can be integrated into your rehabilitation to optimize full recovery.

- Acupuncture
- Massage therapy
- Manual Fascial Stretch Therapy™
- Personal training
- Gym membership
- Prenatal fitness classes
- Ergonomics assessment
- Transition training
- Titleist Performance Institute Certified Golf Fitness Instruction

Whether pain, functional, performance, endurance, or balance limitations have brought you here, your physical therapist will form a plan for you to achieve life-long health and wellness. It is important to us that you not only make progress toward your individual goals, but that you also have an experience that encourages you to reach for and meet your whole potential.

OCEAN PHYSICAL THERAPY Inc.

spine & sports rehab., Pilates & fitness training

In an effort to help you to gain the most benefit from our services, please read the following information. Please acknowledge that you have read, and agree to abide by, the policies below by signing the last page of this agreement.

CHILDREN IN THE GYM AREA: In order to ensure safety for all, children not being seen as patients will not be allowed in the gym area. We ask that you do not bring children with you if there is the possibility they will interfere with your own or other patient's treatment procedures.

CANCELLATIONS OR NO-SHOWS: We require 24 hours notice to cancel or change an appointment (our office has voice-mail to allow you to call at any time including over the weekend or on holidays.) **If you do not provide 24 hours notice of cancellation or change, a $60.00 fee will be charged to you and will be due upon your next visit**. The reason for this charge is that we reserve the appointment time solely for you and we will not be able to fill that appointment time without adequate advance notice. Rescheduled appointments should be made during the same week as the original appointment.

HIPAA NOTICE OF PRIVACY PRACTICES: This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. By signing this page below, you are acknowledging that you have read a copy of this notice.

FEES AND INSURANCE BILLING: Your insurance is a contract between you and your insurance company. Professional services are rendered to you, not the insurance company. Almost every medical plan has a deductible amount and a provision for limiting dollar disbursement by the insurance company for covered services. RARELY IS INSURANCE COVERAGE AT 100%.

If there are any questions regarding your bill, it will be YOUR RESPONSIBILITY to contact your insurance company regarding the amount due. If we have not received reimbursement from your insurance carrier after 60 days, the balance will become your responsibility and is immediately due and payable.

It is YOUR responsibility to know your physical therapy insurance coverage and benefits.

Should you prefer treatment above and beyond your insurance limitations, a 60 minute, one-on-one appointment may be booked with your therapist for $150.00 per visit. Your insurance cannot be billed for these special treatments.

ATTENTION MEDICARE PATIENTS: AS OF 2010, MEDICARE HAS INSTATED A PHYSICAL THERAPY BENEFIT CAP OF $1860.00 PER YEAR. Questions, please call the local Medicare provider at (800)633-4227 or visit www.Medicare.gov.

The undersigned certifies that he/she has read the above and agrees to the terms of our policy.

_____ _____

Signature of Patient or Responsible Party Date

Printed Name:_____

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Patient Information

Today's Date: _____

Patient Name: _____ Age: ____ Date of Birth: _____Sex: Female / Male

Address _____City_____Zip_____

Home Phone _____Day Phone _____Cell Phone_____

Emergency Contact _____Relationship_____Phone _____

Email Address _____

Insurance Coverage_____Member/Subscriber# _____

Circle One: Single Married Divorced Widowed Social Security # _____

Referring Doctor: _____Diagnosis: _____

Employer _____Phone _____

Employer Address _____

Height: _____ Weight: _____ Handedness: Right / Left Do you smoke? Yes / No

Are you a previous patient? Yes / No How did you hear about us? _____

Date of injury or onset of symptoms: _____Work-related /Auto accident Surgery:_____Date:_____

Describe how this injury occurred: _____

_____

Management of injury to date: Physical Therapy / Chiropractic / Acupuncture / Ice / Heat / Other / None

Please list medications used relating to this injury:_____

Have you had: Injections / X-rays / CAT scans / MRI's for this problem? Date(s): _____ Body part: _____

MEDICAL HISTORY

Describe previous injuries or surgeries you have had:

_____ **Date** _____

_____ _____

Please write 'YES or NO' as appropriate and give details only if not addressed above:

YES/NO		DETAILS
_____	Do you have a metal implant or pacemaker in your body?	_____
_____	Are you pregnant?	_____
_____	Do you have any loss/transplant/impairment of any organ?	_____
_____	Have you been diagnosed with cancer in any area?	_____
_____	Have you had weight loss not associated with a nutritional change?	_____
_____	Is your general health status poor?	_____
_____	Are you severely depressed?	_____
_____	Do you drink alcohol?	_____

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Please write 'YES or NO' as appropriate and give details only if not addressed above

YES/NO		**DETAILS**
Do you have irregularities of the following systems?		
_____	Head, ears, nose or throat	_____
_____	Lungs (asthma, cough, etc.)	_____
_____	Heart (high blood pressure, heart attacks, etc.)	_____
_____	Circulation (blood clots, poor circulation, etc.)	_____
_____	Gastro-intestinal (ulcers, etc.)	_____
_____	Eyes (including recent change in acuity)	_____
_____	Genitourinary (kidney, incontinence, etc.)	_____
_____	Musculoskeletal (fractures, sprains, arthritis, etc.)	_____
_____	Neuromuscular (weakness, strains, numbness etc.)	_____
_____	Neurological (stroke, Parkinson's, seizures, etc.)	_____
_____	Metabolic/endocrine (thyroid, diabetes, etc.)	_____
_____	Skin (rashes, etc.)	_____
_____	Dental (TMJ, etc.)	_____

OB/GYN HISTORY

_____	Number of pregnancies	_____
_____	Number of vaginal deliveries	_____
_____	Number of cesarean deliveries	_____
_____	Number of episiotomies	_____
_____	Birth weight of largest baby	_____
_____	(Y/N) Any trouble healing after delivery?	_____
_____	Date of last pap smear	_____

Do you have a history of sexual abuse or trauma? Y N
Are you having regular periods/ menstrual cycles? Y N
Do you have frequent urinary tract infections? Y N

CURRENT COMPLAINTS

Pain symptoms (Please check all that apply):

Do you have pain with:

- _____ Sexual intercourse
- _____ Pelvic exam
- _____ Tampon use
- _____ Urination
- _____ Having a bowel movement
- _____ Back, leg, groin, abdominal pain
- _____ Other _____

Location of pain: _____

Nature of pain: constant/intermittent/occasional burning/aching/shooting/sharp/dull

Bladder symptoms (Please check all that apply):

Do you lose control of urine when you:

- _____ Cough/ sneeze/ laugh
- _____ Lift/ exercise/ dance/ jump
- _____ On the way to the bathroom
- _____ Hear running water
- _____ Other _____

Do you:

- _____ Wet the bed
- _____ Have difficulty starting a stream of urine
- _____ Strain to empty your bladder
- _____ Feel unable to empty bladder fully
- _____ Have a falling out feeling
- _____ Have pain with a full bladder
- _____ Have a strong urge to urinate
- _____ Urinate more than 7 times/day
- _____ Other _____

Bowel symptoms (Please check all that apply):

Do you:

- _____ Strain to have a bowel movement
- _____ Leak / stain feces
- _____ Include fiber in your diet
- _____ Have diarrhea often
- _____ Take laxatives / enema regularly
- _____ Leak gas by accident
- _____ Have pain with bowel movement
- _____ Have a very strong urge to move your bowels

How often do you move your bowels: _____ per day/week

Most common stool consistency

____ liquid ___ soft ___ firm ___ pellets ___ other____

ACTIVITIES/WORK

I am currently on: Full-Time _____ Part-Time _____ Disability _____ Other _____

Has your doctor restricted you from any activity: Lifting _____ lbs. Bending _____ Other _____

Previous to this injury my NORMAL job/activity status was *(circle as many as apply):*

Part-time / Full-time WORKER at _____Company with job title of _____

Part-time / Full-time HOMEMAKER and/or RETIRED

Primary / Secondary CARETAKER of children ages _____

Part-time / Full-time _____ grade STUDENT at _____ School majoring in_____

I have to commute _____ minutes each way _____ times a week.

PATIENT GOALS

What goals would you like to meet by the end of physical therapy? _____

_____