

Date: ___/___/___



SANTIAGO
THERAPY CENTER

Welcome to our office. This form must be filled out in its entirety.

PATIENT INFORMATION

Patient Name: _____

[] MALE [] FEMALE

DOB: ___/___/___ Age: ___ S.S.# _____

Home Address: _____

City: _____ State: ___ Zip: _____

Home Phone: _____

Cell Phone: _____

Whom may we thank for referring you? _____

Primary Physician: _____

Phone # _____

E-mail: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____

Home Address: _____

City: _____ FL: ___ Zip: _____

Phone #: _____

Relationship: _____

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship: _____

INSURANCE INFORMATION

Front and Back copy of insurance card is REQUIRED

Primary Insurance: _____

Claims Address: _____

City: _____ Sate: ___ Zip: _____

Phone # _____

Insured Name (if different from patient): _____

ID # _____ Group # _____

Secondary Insurance _____

Claims Address: _____

City: _____ Sate: ___ Zip: _____

Phone # _____

Insured Name (if different from patient): _____

ID # _____ Group # _____

AUTO ACCIDENT (if applicable)

Date of Accident: _____

Insurance: _____

Claim #: _____

Insured Name: _____

Adjuster Info: _____

Adjuster #: _____

PAYMENT AUTHORIZATION

I hereby authorize payment of the insurance benefits covering all medical charges submitted by Santiago Therapy Center.

Patient Signature: _____

Guardian (if minor): _____

REFERRING PHYSICIAN: _____ Phone: _____

NPI: _____

MEDICAL HISTORY



1720 W. Dr. Martin Luther King Jr. Blvd.
Tampa, FL 33607

P: (813) 876-7400 F: (813) 877-8145

www.santiagotherapycenter.com

A division of the J.A. Santiago MS, RPT, P.A.

	YES	NO
High Blood Pressure		
Heart Disease		
Rheumatic Fever		
Chest Pain		
Irregular Heart Beat		
Shortness of Breath		
Stroke		
Swelling of Feet		
Frequent Headaches		
Epilepsy		
Depression		
Suicide Attempt		
Psychiatric History		
Phlebitis		
Fainting		
Drug Addiction		
Jaundice		
Diabetes		
Prosthetic Joints		
Metal in your body		

	YES	NO
Gallbladder Disease		
Liver Disease		
Kidney Disease		
Arthritis		
Cancer		
Anemia		
Low Back Pain		
Gout		
Ulcers		
Constipation		
Chronic Diarrhea		
Asthma		
Allergies		
Dizziness		
Alcoholism		
Birth Defects		
Neck Pain		
Hemophilia		
Blood Disorders		
Pregnant		

If you answered YES to any of the above, please explain:

Signature: _____

Date: _____



MEDICAL CONSENT FORM

- 1.) MEDICAL CONSENT: The patient is under the care of Santiago Therapy Center and the undersigned consents to any x-ray, examination, laboratory procedures, diagnostic service, or other services rendered the patient under the general and specific instructions of Santiago Therapy Center.
- 2.) CONSENT TREATMENT: I hereby agree to the performance of treatment services as in the opinion of my physical therapist are deemed necessary.
- 3.) RELEASE OF INFORMATION: Santiago Therapy Center may disclose all or any part of the patient’s record to any person or corporation which is or may be liable under a contract to Santiago Therapy Center or to the patient or to a family member or employer of the patient for all or part of the medical charges, including, but not limited to medical service companies, workers’ compensation carriers, welfare funds or the patient’s employer.
- 4.) ASSIGNMENT OF BENEFITS: In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient said benefits are hereby assigned to Santiago Therapy Center for application on patient’s bill, and it is agreed that Santiago Therapy Center may receive any such payment and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and or patient being responsible for charges not covered by this assignment.
- 5.) FINANCIAL AGREEMENT: The undersigned agrees whether he signs as agent or as patient that in consideration of the services to be rendered to the patient, the hereby individual obligates himself to pay the account in accordance with the regular rates and terms of the facility. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney’s fees and collection fees and collection expenses. A 0.1% service charge will be assessed on all account balances past 30 days. Any dispute will be resolved in our Jurisdiction.
- The undersigned certifies that he has read the foregoing, is the patient, or is duly authorized by the patient as the patient’s general agent to execute the above and accept the terms.

Patient’s Signature

Date

Guardian’s Signature

Date

IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST AUTHORIZE TREATMENT TO BE ADMINISTERED TO PATIENT.

PATIENT INJURY IDENTIFICATION



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Name: _____

Please fill in the following information to accurately evaluate and treat. Draw or shade in the location of your body injuries as a result of your most recent accident. Describe by connecting a line to the body diagram.

Note pain, stiffness, weakness, numbness, cuts, black and blue marks, swelling, scars, etc. Carefully scan your entire body pushing on areas to note tenderness and move arms, legs, back, etc. Include pain during activities such as lifting, bending, working, etc. This is very important so the doctor can concentrate and not overlook any injuries



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MEDICAL RECORD RELEASE

Date: ____/____/____

Requesting from: _____

Patient name: _____

Attention: _____

Patient D.O.B.: ____/____/____

Phone: _____

Social Security #: _____

Fax#: _____

Comments:

Dates of service: from _____ to _____

I hereby authorize the release of my medical records, X-rays and any other pertinent information related to myself, the patient, to Santiago Therapy Center, for the provision of care and obtaining reimbursement.

Patient Signature

Guardian Signature (if patient is underage)



NOTICE OF INITIATION OF TREATMENT

DATE: _____

INSURANCE: _____

ADDRESS: _____

PATIENT: _____

INSURED: _____

CLAIM #: _____

POLICY #: _____

This shall serve as notification that the patient named above has initiated treatment with:

Santiago Therapy Center
J.A. Santiago, MS, RPT
1720 W. Dr. Martin Luther King Jr. Blvd.
Tampa, FL 33607
813-876-7400

As prescribed by Florida Statute 627.736 (5)(b) 6. (c) if this notice has been submitted with 21 days after the first examination or treatment of the claimant, claim forms may include charges for treatment or services rendered up to 75 days before the postmark of the claim.

Patient's Signature Date

Guardian's Signature Date

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