DEFY
THERAPY & WELLNESS

Defy Therapy and Wellness Electronic Intake

This is our encrypted, HIPAA compliant online registration system. Your information will remain private and is transmitted directly to our clinic. Please fill out all necessary information and read through our company policies. If you have any questions, please call PHONE NUMBER

Phone Number

Area Code Phone Number

Email

example@example.com

Phone Number

Area Code Phone Number

Full Name *

First Name Last Name

Gender *

- Male
- Female
- Prefer not to say
-

Preferred Name

Preferred Name

Date of Birth *

Month Day Year

Phone Number *

Area Code Phone Number

Email *

example@example.com

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Have you been to Defy Therapy and Wellness before? *

- ○ Yes
- ○ No

How did you hear about us? (check all that apply) *

- ☐ My doctor or specialist
- ☐ Insurance Carrier's Website
- ☐ Peer Recommendation
- ☐ Google Search
- ☐ Yelp Reviews
- ☐

Insurance Information

By furnishing your insurance information prior to your initial evaluation, our staff can provide you with information regarding your physical therapy benefits. Zamoyski, LLC also encourages patients to contact

their insurance carrier for more detailed information regarding their policy.

Primary Insurance *

- ○ Blue Cross Blue Shield
- ○ Aetna
- ○ United Healthcare
- ○ Cigna
- ○ Medicare
- ○ PHCS
- ○ Auto Accident Insurance
- ○ Worker's Compensation Claim
- ○ Humana
- ○ Self Pay
- ○ _____

Group number *

Policy ID # *

Secondary Insurance (if applicable)

Secondary Policy ID #

If a lawyer or case manager is involved with your case, please provide their contact information and claim number if applicable:

Name, address, phone

Special Instructions regarding email use:

Emergency Contact *

First Name Last Name

Phone Number *

Area Code Phone Number

Health Questions

Please provide answer regarding you current health status and the reason for your visit.

What area(s) of the body are you requesting treatment for? (Check all that apply) *

- [ ] Neck
- [ ] Upper Back
- [ ] Shoulder
- [ ] Elbow
- [ ] Hand/Wrist
- [ ] Lower Back
- [ ] Hip
- [ ] Knee
- [ ] Ankle/Foot

- [ ] Dizziness
- [ ] Headache
- [ ]

Any history of the problem you would like to add?

Diagnostic Imaging Studies taken for this issue:

- [ ] X-Rays
- [ ] MRI/MRA
- [ ] CT Scans
- [ ] None
- [ ]

Do you have a referral from a doctor, specialist or dentist? *

- ○ Yes
- ○ No

Please provide the physician's name. *

Height - Feet

Inches

General Medical History *

- [ ] Heart Disease
- [ ] Pacemaker
- [ ] Stroke
- [ ] Diabetes
- [ ] Lung Disease

- [ ] Asthma
- [ ] High Cholesteral
- [ ] Hernias
- [ ] Nervous Condition
- [ ] Bleeding Disorders
- [ ] Seizures or Epilepsy
- [ ] Open Heart Surgery
- [ ] High Blood Pressure
- [ ] Psychological Disorders
- [ ] Diabetes (Type 1 or 2)
- [ ] Depression
- [ ] I HAVE NONE OF THESE CONDITIONS TO MY KNOWLEDGE
- [ ]

History of Broken Bones?

History of Metal Implants?

History of Cancer?

History of Surgery?

History of Bone Fusions?

Other

Are you pregnant or planning a pregnancy?

- [ ] Yes
- [ ] No

Do you take any prescribed medications, over-the-counter medications, vitamins or supplements?

- ○ Yes
- ○ No

Please provide name of medications you take regularly:

Have you been admitted to the hospital in the past year

- ☐ Yes
- ☐ No

If yes, Why? Please include date of hospitalization and discharge.

Are you currently under the care of a home healthcare nurse and/or therapist? (Nursing care at home: blood pressure checks, injections, wound care, insulin, etc physical or occupational therapy care at home, cleaning service at home, etc)

- ☐ Yes
- ☐ No

If yes, Why? Please include date started and discharge.

Disclosure Authorization

The use and/or disclosure authorized. Name the individual and/or organization than your referring physician and your insurance company that you are also authorizing to receive and use your personal health information.

Dr./Organization/Individual

Insurance

Agent

For what purpose are you authorizing your personal health information to be used and/or disclosed

- ☐ Medical Records
- ☐ Billing Purposes
- ☐

Notice of Information Practices and Privacy Statements

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU, MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS OR COMMENTS ABOUT THIS NOTICE PLEASE CONTACT ZAMOYSKI, LLC CEO/OWNER KELSEY ZAMOYSKI AT (305) 947-7788.

WHO WILL FOLLOW THIS NOTICE:

ZAMOYSKI, LLC

17100 COLLINS AVE STE 210, SUNNY ISLES BEACH, FL 33160

PHONE: (305) 947-7788; FAX: (305) 947-5458

THIS NOTICE DESCRIBES OUR PRIVACY PRACTICES. ALL THESE ENTITIES, SITES AND LOCATIONS FOLOW THE TERMS OF THIS NOTICE. IN ADDITION, THESE ENTITIES, SITES AND LOCATIONS MAY SHARE PHI WITH EACH OTHER ON BEHALF OF TREATMENT, BILLING OR HEALTHCARE OPERATION PURPOSES DESCRIBED IN THIS NOTICE.

WE ARE REQUIRED BY LAW: TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF ITS LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR HEALTH INFORMATION. WE ARE REQUIRED BY LAW TO FOLLOW THE TERMS AND CONDITIONS OF THE EFFECTIVE NOTICE.

WE MAY DISCLOSE YOUR HEALTH INFORMATION: FOR APPOINTMENT REMINDERS, TO OTHER HEALTHCARE PROFESSIONALS WITHIN OUR PRACTICE FOR THE PURPOSE OF TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. WE MAY DISCLOSE YOUR HEALTH INFORMATION TO YOUR INSURANCE PROVIDER FOR PAYMENT/HEALTHCARE OPERATIONS, TO COMPLY WITH STATE WORKERS' COMPENSATION LAWS, TO NOTIFY A FAMILY MEMBER IN THE EVENT OF AN EMERGENCY, AND/OR AS REQUIRED BY LAW AND/OR TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY.

YOU HAVE THE FOLLOWING RIGHTS TO YOUR PHI RECORDS: YOU HAVE THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES/DISCLOSURES OF YOUR PHI AND AMENDMENTS TO YOUR PHI, HOWEVER, WE ARE NOT REQUIRED TO AGREE TO THE RESTRICTIONS AND/OR AMENDMENTS YOU REQUESTED. YOU HAVE THE RIGHT TO: HAVE YOUR PHI RECEIVED/COMMUNICATED THROUGH AN ALTERNATIVE METHOD OR LOCATION UPON YOUR REQUEST. YOU HAVE THE RIGHT: TO INSPECT AND COPY YOUR PHI, TO A COPY OF THIS NOTICE, TO REQUEST CONFIDENTIAL COMMUNICATIONS, AND YOU HAVE THE RIGHT TO REQUEST AN ACCOUNTING OF DISCLOSURE.

CHANGES TO THIS NOTICE: WE RESERVE THE RIGHT TO AMMEND THIS NOTICE OF PRIVACY PRACTICES AT ANY TIME IN THE FUTURE, AND WILL MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INFORMATION THAT IT MAINTAINS. UNTIL SUCH AMENDMENT IS MADE, WE ARE REQUIRED BY LAW TO COMPLY WITH THIS NOTICE.

COMPLAINTS ABOUT YOUR PRIVACY RIGHTS: OR HOW WE HAVE HANDLED YOUR HEALTH INFORMATION SHOULD BE DIRECTED TO OUR PRIVACY OFFICE BY CALLING THE OFFICE (305)947-7788 OR MAKE AN APPOINTMENT FOR A PERSONAL IN PERSON CONFERENCE WITHIN 2 WORKING DAYS. IF YOU ARE NOT SATISFIED WITH THE MANNER IN WHICH THIS OFFICE HANDLES YOUR COMPLAINT, YOU MAY SUBMIT A FORMAL COMPLAINT TO: DDHA, OFFICE OF CIVIL RIGHTS, 200 INDEPENDENCE AVE S.W, ROOM 509 F HHH BUILDING, WASHINGTON, DC 20201.

I have read the ZAMOYSKI, LLC HIPAA statement. *

☐ I have read this statement

Zamoyski, LLC Policies

Below are our office's policies; please read carefully and sign at the bottom. If you have questions, please call PHONE NUMBER

CONSENT TO TREAT: I AUTHORIZE ZAMOYSKI, LLC TO PROVIDE OCCUPATIONAL/PHYSICAL/SPEECH THERAPY AND/OR REHABILITATION SERVICES AS PRESCRIBED BY MY PRIMARY CARE PHYSICIAN OR BY ANY OTHER PHYSICIAN WHO MAY BE TREATING ME, INCLUDING ALL DIAGNOSTIC AND THERAPEUTIC TREATMENTS THAT MAY BE CONSIDERED NECESSARY AND IN THE JUDGEMENT OF THE PHYSICIAN AND/OR THERAPIST AFTER THE INITIAL EVALUATION. I HEREBY RELEASE ZAMOYSKI, LLC FROM ALL LIABILITY INCURRED AS A RESULT OF MEDICAL TREATMENTS PROVIDED BY THE EMPLOYEES OF THE AGENCY.

EMERGENCY CONTACT: I UNDERSTAND THAT DURING THE COURSE OF MY PROGRAMMED SESSIONS, THE NEED FOR EMERGENCY TREATMENT AND/OR TRANSFER TO A HOSPITAL MAY BECOME NECESSARY. I UNDERSTAND THAT ZAMOYSKI, LLC DOES NOT PROVIDED EMERGENCY MEDICAL CARE. THEREFORE, SHOULDER THE NEED FOR SUCH TREATMENT AND/OR TRANSFER BE DEEMED NECESSARY BY MY THERAPIST, THE AGENCY'S STAFF WILL CALL 911. I ASSUME SOLE RESPONSIBILITY FOR ALL CHARGE THAT MAY ARISE. I UNDERSTAND THAT MY EMERGENCY CONTACT WILL BE INFORMED IF SUCH EVENTS TAKE PLACE.

CHANGING AUTHORIZATION: I UNDERSTAND THAT I MAKE REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVEN A WRITTEN NOTICE TO KELSEY ZAMOYSKI, PRIVACY OFFICER AT ZAMOYSKI, LLC. HOWEVER, I UNDERSTAND THAT I MAY NOT REVOKE THIS AUTHORIZATION FOR ANY ACTIONS TAKEN BEFORE RECEIPT OF MY NOTICE TO REVOKE IT. IN ADDITION, I UNDERSTAND THAT IF I AM GIVING THIS AUTHORIZATION AS A CONDITION TO OBTAIN INSURANCE COVERAGE, AND I REVOKE THIS AUTHORIZATION, THE INSURANCE COMPANY HAS A RIGHT TO CONTEST MY CLAIMS UNDER THE INSURANCE POLICY.

SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT: (THIS SECTION IS OVERRULED IF THE PATIENT AGREES TO SECTIONS TITLED "DISCLOSURE OF AUTHORIZATION" AND CONSENT TO TREAT & 4: I UNDERSTAND THAT SIGNING THIS AUTHORIZATION TO ZAMOYSKI, LLC UNDER MOST CIRCUMSTANCES, IS NOT A CONDITION OF TREATMENT, ENROLLMENT, ELIGIBILITY, OR PAYMENT, FOR BENEFITS. HOWEVER, I UNDERSTAND THAT SIGNING AN AUTHORIZATION HTAT PERMITS THE

USE AND/OR DISCLOSURE OF MY PHI FOR RESEARCH PURPOSES MAY BE A CONDITION OF MY TREATMENT IF I AM UNDERGOING RESEARCH RELATED TREATMENT. ALSO, I MAY BE REQUIRED TO SIGN AN AUTHORIZATION IF MY TREATMENT IS PROVIDED SOLELY FOR THE PURPOSE OF CREATING PHI FOR DISCLOSURE TO A THIRD PARTY; AND UNDER SOME CIRCUMSTANCES, A HEALTH PLAN MAY CONDITION MY ENROLLMENT IN A HEALTH PLAN OR ELIGIBILITY FOR BENEFITS ON ME PROVIDED AN AUTHORIZATION PERMITTING THE HEALTH PLAN TO MAKE ENROLLMENT AND ELIGIBILITY DETERMINATIONS.

INDIVIDUAL PATIENT'S SIGNATURE: I HAVE HAD THE CHANCE TO READ AND THINK ABOUT THE CONTENT OF THIS AUTHORIZATION FORM AND I AGREE WITH ALL STATEMENTS MADE IN THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AM CONFIRMING MY AUTHORIZATION FOR USE/AND DISCLOSURE OF THE PHI DESCRIBED IN THIS FORM WITH ZAMOYSKI, LLC AND EACH OF THE ORGANIZATIONS NAMED IN THIS FORM.

2019 Patient Responsibility Agreement

Below is our office's patient responsibility; please read carefully and sign at the bottom. If you have questions, please call PHONE NUMBER

We bill all insurance payers although we may not be contracted with all insurance companies. If we are a network provider for your insurance company, they will pay for our services at the negotiated rate and we will apply the appropriate payments and adjustments to your account. It is your responsibility to pay deductibles, co-payments or coinsurances. All out of network charges will be negotiated as discussed per this agreement.

If pre-authorization is required, it is the responsibility of the provider to initiate the authorization process. If the authorization is not approved at the time of your evaluation, you will be given the option to have the evaluation without authorization and risk denial and financial responsibility or reschedule until authorization is approved. Upon the completion of your evaluation, we will bill your insurance.

Definitions:

Deductible- The deductible amount depends upon the type of plan that you have with your insurance carrier. This is the amount that must be paid by you prior to your insurance making any payments on your behalf.

Copayment- is a predetermined fee an individual will pay for health care services, in addition to what the insurance covers. For example, some insurance payors require a $10 copayment for each office visit, regardless of the type or level of services provided during the visit.

Coinsurance-is a predetermined percentage an individual will pay for health care services, in addition to what the insurance covers. For example, some insurance requires a 20% coinsurance. We will bill your insurance and apply all payments and adjustments. You will be responsible for the 20% that your insurance does not cover.

We have determined the following to be your responsibility per the phone call to your insurance company. THIS IS NOT A GUARANTEE OF PAYMENT.

By checking here, you are agreeing to the above policies and consenting to the use of your electronic signature in lieu of an original signature on paper. You have the right to request that

you sign a paper copy instead. By checking here, you are waiving that right. After consent, you may, upon written request to us, obtain a paper copy of an electronic record. No fee will be charged for such copy and no special hardware or software is required to view it. Your agreement to use an electronic signature with us for any document will continue until such time as you notify us in writing that you no longer wish to use electronic signature. You should always make sure that we have a current email address in order to contact you regarding any changes, if necessary. *

☐ I agree to the above policies and use of electronic signatures

Name

First Name Last Name