S.T.A.R.S.
ST AUGUSTINE
REHABILITATION SPECIALISTS

General Information

First	Last	MI	**Nickname**
SSN - -	Gender ☐ **Male** ☐ **Female**	Date of Birth / /	

Marital Status (please circle) **Single** ☐ **Married** ☐ **Other** ☐ **Widow** ☐ **Divorced** ☐	Patient Status (please circle) **Not Applicable** ☐ **Employed** ☐ **Student** ☐

Contact Information

Home Address	City	State	**Zip Code**
Home Phone Number ( )	Cell Phone Number ( )	Work Phone Number ( )	
Email Address			

Emergency Contact

Emergency Contact	Relation	Phone ( )
Is this contact permitted to discuss your medical conditions?	**YES** ☐ **NO** ☐	
Emergency Contact	Relation	Phone ( )
Is this contact permitted to discuss your medical conditions?	☐ **YES** ☐ **NO**	

Referral Information

Referring Physician			
Primary Care Physician			
Is this post-surgical?	● **YES** ○ **NO**	Date of Surgery	
Is this work Related?	● **YES** ○ **NO**	Date of Injury	State of Injury
Is this an auto accident?	● **YES** ○ **NO**	Date of Accident	State of Accident
If yes to auto, do you have an attorney?	○ **YES** ○ **NO**	Name of Attorney	Phone Number

How did you find our clinic?

Physician referral ☐ **A friend or relative referred me** ☐ **Internet search** ☐ **Former patient** ☐ **Other** ☐

SAINT AUGUSTINE REHABILITATION SPECIALISTS LLC • 105 MARINER HEALTH WAY, SUITE 213
ST. AUGUSTINE, FLORIDA 32086 • OFFICE: 904-217-4259 • FAX: 904-217-4251

Medical History

Name:

DOB: / /

Your primary complaint: ____________________

Please feel free to comment on any signs and symptoms or circumstances you feel may better help us to address your complaints:

Existing or Relevant Previous Conditions

Allergies	○ Yes ● No	Dizzy Spells	○ Yes ○ No	MRSA	○ Yes ○ No
Anemia	○ Yes ● No	Emphysema/Bronchitis	○ Yes ○ No	Multiple Sclerosis	○ Yes ○ No
Anxiety	○ Yes ● No	Fibromyalgia	○ Yes ○ No	Muscular Disease	○ Yes ○ No
Arthritis	○ Yes ● No	Fractures	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Asthma	○ Yes ● No	Gallbladder Problems	○ Yes ○ No	Parkinsons	○ Yes ○ No
Autoimmune Disorder	○ Yes ● No	Headaches	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No
Cancer	○ Yes ● No	Hearing Impairment	○ Yes ○ No	Seizures	○ Yes ○ No
Cardiac Conditions	○ Yes ○ No	Hepatitis	○ Yes ○ No	Smoking	○ Yes ○ No
Cardiac Pacemaker	○ Yes ○ No	High/Low blood pressure	○ Yes ○ No	Speech Problems	○ Yes ○ No
Chemical	● Yes ○ No	High Cholesterol	○ Yes ○ No	Strokes	○ Yes ○ No
Circulation Problems	○ Yes ○ No	HIV/AIDS	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Currently Pregnant	○ Yes ● No	Incontinence	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Depression	○ Yes ● No	Kidney Problems	○ Yes ○ No	Vision Problems	○ Yes ○ No
Diabetes	○ Yes ● No	Metal Implants	○ Yes ○ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

☐ Injury as a result of a fall in the past year?

☐ Two or more falls in the last year?

Surgical History

Body Region:__________ Surgery Type:__________ Date:______,____, ______

Body Region:__________ Surgery Type:__________ Date:______,____, ______

Body Region:__________ Surgery Type:__________ Date:______,____, ______

Body Region:__________ Surgery Type:__________ Date:______,____, ______

Body Region:__________ Surgery Type:__________ Date:______,____, ______

Therapist Reviewed

Date

Medication List

Name: **DOB: / /**

Prescribed Medications

Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
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Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________

☐ **Currently not taking any medications**

Vitamins & Herbal Supplements

Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________

☐ **Currently not taking any vitamins and/or herbal supplements**

Over the Counter Medications

Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________
Drug:__________ Dosage:______ Frequency:________ Route:________ Reason Taking: __________

☐ **Currently not taking any over the counter medications**

______________________________ ______________
Therapist Reviewed Date

ST.A.R.S.
ST AUGUSTINE
REHABILITATION SPECIALISTS

CONSENT TO TREAT:

I consent to the procedures which may be performed during my treatment and care at **SAINT AUGUSTINE REHABILITATION SPECIALISTS LLC**, including emergency treatment or services. These may include, but are not limited to, any and all testing and measurements necessary for my evaluation, and any and all therapeutic procedures (exercise, joint mobilization, manual stretching, etc.) necessary for my treatment and under the direction and supervision of my Therapist. I understand that it is my right and responsibility to question freely any treatment, and in no way am I being guaranteed a certain result from the procedures rendered. That being noted it is the responsibility of your therapist at ST.A.R.S. to practice with the most current and reasonable experiential and evidence based methods.

Initials: ________

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT):

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Saint Augustine Rehabilitation Specialists LLC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Initials: ________

CANCEL/NO SHOW/LATE POLICY:

We strive to make sure you are scheduled in the time slot that you prefer. When you do not comply with the treatment schedule by missing appointments, the outcome of recovery will be affected. We want to stress the importance of coming to all of your scheduled appointments. As a courtesy, St Augustine Rehabilitation Specialists, LLC offers three ways to receive appointment reminders: text message, email and/or phone. If for any reason, you cannot come to a scheduled appointment, please notify us at least 24 hours in advance.
You may be charged a **no-show/cancellation fee of $40.00** for any missed appointments.
Note that when you do not show or when you cancel three (3) consecutive appointments, your treating Physician will be notified and you may be removed from our appointment schedule.
We understand that unforeseen circumstances may arise and we will determine on a case by case if you will be charged the fee.

Initials: ________

I understand and have fully reviewed the contents of the Consent to Treatment, Notice of Privacy Practice and Appointment Reminder policies.

________________________________ ________________
Patient/Legal Guardian Signature Date

____
Witness

AUTHORIZATOIN OF RELEASE OF SPECIFIC INFORMATION:

As required by the Health Information and Accountability Act (HIPAA) of 1996, you have the right to request that communications concerning your personal health information be made through confidential channels. This includes communication with any doctor's office and retrieving all records and reposts related to your conditions. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

Please reply to all:		
May we call your home and/or cell phone and leave a message?	YES ● NO ○	
May we email/text you?	YES ● NO ○	
May we email/text your doctor?	YES ● NO ○	
May we discuss your condition with family members?	YES ● NO ○	If yes, please list their names.
May we fax copies of information to other doctor's offices in addition to your referring doctor?	YES ● NO ○	If yes, please indicate which doctor.
May we have permission to take and use photo/video for social media/webiste?	YES ○ NO ○	

AUTHORIZATION TO RELEASE MEDICAL RECORDS:

Saint Augustine Rehabilitation Specialists, LLC is authorized to release my information as necessary to other health care organizations, including copies of my therapy and medical records to process payment claims for health care services which have been provided. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Saint Augustine Rehabilitation Specialists, LLC has already relied on the use of disclosure of the health information or if my authorization was obtained as a condition of my obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, write a letter to Saint Augustine Rehabilitation Specialists, LLC.

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except when (1) my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party or (3) an authorization is required for health plan eligibility or enrollment or a risk rating determination. Failure to sign an authorization may result in an inability to obtain certain benefits in these cases.

I understand I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient information to the above named person or organization.

_______________________________ _______________________

Patient/Legal Guardian Signature Date

____

Witness