SENSORY THERAPEUTICS INC. - PATIENT INFORMATION SHEET

Name: ____ **Date of Birth:** ______________

Home Phone # (   ) ____________________ **Cell Phone # (   )** ____________________
Indicate if you prefer a phone ( ) or Text ( ) reminder of your appt, circle the # above.

Email: ____________________________________ **( ) Email Billing Statement or ( ) Paper?**

Marital Status: (S) (M) (W) (D)   Sex: (M) (F)

Home Address: ____

City: _________________________________ **State:** _________ **Zip Code:** _____________

Permanent or Billing Address (if different than above):

Address: ____

City: __________________________________ **State:** __________ **Zip Code:** _________

Occupation: _________________________ **Employer:** _____________________________

Spouse: ________________________________ **Spouse's Date of Birth:** _______________

Emergency Contact: ________________________________ **Phone:** ____________________

Primary Insurance: ____

Secondary Insurance: ____

Primary care Physician: ____
☐ **I request release of information to my primary care MD (please check if desired)**

HAVE YOU HAD PHYSICAL, SPEECH OR OCCUPATIONAL THERAPY IN 2022?__
ARE YOU CURRENTLY RECEIVING NURSING OR THERAPY SERVICES?
Yes _________ **No** ________ **If so, date of Discharge** ________________________________
Circle type: OT, PT, SPEECH, HOME HEALTH, NURSING CARE

Dizziness, imbalance and vertigo are very unpredictable and can occur at any time. I, as the patient, must take the proper precautions and responsibility to avoid accidents and mishaps; this may include driving a car, operating heavy machinery, working in precarious situation (ladder, rooftops) or even during basic daily activities. I understand the implications of the above cautionary information and accept responsibility for exercising care and judgment with respect to my personal safety and the safety of others. ***Please Initial:*** ____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY
ASSIGNMENT OF BENEFITS

Medicare Patients: If Medicare is your primary insurance provider, we do accept Medicare assignment and bill through a Medicare intermediary, First Coast Service Options, Inc. of Jacksonville, Florida in applying for payment under Title XVII of the Social Security Act. Your explanation of benefits will be from this carrier showing billed charges and the 20% you are responsible for. If you have a Medicare supplemental policy or secondary insurance, we will be happy to verify your coverage and benefits and submit the bill to that insurance company on your behalf after Medicare has been paid. You are responsible for any amounts not covered by your insurer. This can be any portion of the 20% Medicare allowable as well as annual deductibles. Not all secondary insurances pay the provider for therapy services, any amount that is not paid is your responsibility. You will not be billed for any charges that Medicare does not allow.

All Insurances: If your medical insurance requires an annual deductible, a co-payment or coinsurance, this payment will be expected at the time of services. We will bill your insurance upon request for your direct reimbursement. If your insurance carrier denies any part of your claim, or if you or your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Sensory Therapeutics Inc. for providing rehabilitative services to me or the named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Sensory Therapeutics Inc. I agree to pay to Sensory Therapeutics Inc. the full and entire amount of all bills incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier. I guarantee payment of any and all bills rendered for services not covered or allowable by insurance. "Professional fees are due at the time services are rendered. I agree, if it becomes necessary to collect fees through the services of an attorney or collections agency, to pay all reasonable attorney and collection fees and costs".

After reading the above explanation I am aware of my financial responsibilities. Verification of insurance coverage is not a guarantee that payment will be made.

PATIENT SIGNATURE____DATE______________

CONSENT FOR TREATMENT
AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Sensory Therapeutics Inc. to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures relating to my diagnosis.

I authorize Sensory Therapeutics Inc. to release to appropriate agencies any medical or other information acquired in the course of my or the above patient's assessment and treatment. Please sign below that you have read the above information.

PATIENT SIGNATURE____DATE______________

NOTICE OF PRIVACY PRACTICES

Sensory Therapeutics Inc. 210 Jupiter Lakes Blvd. Ste. 4201 Jupiter, FL 33458

Privacy Officer: Rose Ann Curboy MS, OTR/L (561) 745-0028

Effective Date: September 20, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

If you have any concerns, questions, or to exercise any of these rights regarding your health care information, please contact me at: **Sensory Therapeutics Inc.**
PO Box 575 Jupiter, FL 33468-0575 (561) 745-0028 sensorytherapeut@bellsouth.net

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Roosevelt Freeman, Regional IV Manager; Office for Civil Rights; U.S. Department of Health and Human Services; Sam Nunn Atlanta Federal Center, Suite 16T70; 61 Forsyth Street, S.W.; Atlanta, GA 30303-8909 Voice Phone (800) 368-1019 FAX (404) 562-7881 TDD (800) 537-7697 OCRMail@hhs.gov. The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Acknowledgement of Receipt of Privacy Notice

I certify that I have received and read the Notice of Privacy Policies. I understand the above HIPAA regulations' detailing how my information may be used and disclosed as permitted under Federal and State Laws. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

____

☐ **I request release of information to my primary care physician (please check if desired).**

______________________________ ______________________

(Patient Signature) **(Date)**

Sensory Therapeutics, Inc.
210 Jupiter Lakes Blvd.
Building 4000, Suite 201
Jupiter, FL 33458

1. Are you currently receiving Home Health Care services? Yes ______ No ______

    If yes, then who is paying for it?

    Medicare? Yes ______ No ______

    Long Term Care Insurance? Yes ______ No ______

    Private Pay? Yes _______ No ______

2. Have you RECENTLY received Home Health care? Yes_____ No _____

    If YES:

    Date of Discharge:______________________

    Company Providing Service ______________________________

3. Are you receiving Hospice care? Yes ______ No ______

4. Is the therapy being prescribed by your doctor for injuries related to an accident?
    Yes ______ No______

    If Yes, please explain briefly: _____________________________

____

Patient Signature ____

Date ____

NAME ____

COVID 19 Screening

1. Are you experiencing any of the following symptoms? CIRCLE ANY THAT APPLY

- Fever
- Shortness of breath
- Cough
- Runny/stuffy nose
- Sore throat
- Headache/Body aches
- Fatigue
- Loss of Smell and Taste

2. Have you had exposure to a COVID 19 patient in last 14 days? YES NO

3. Have you traveled to an affected geographic region with the last 14 days? YES NO

4. Have you been diagnosed with COVID 19? YES NO

If YES: When? ________________ Date

Have you had a follow-up negative test? YES NO

If YES, When? ________________ Date

5. Have you been vaccinated? YES NO

6. Have you had a COVID 19 Booster? YES NO

If YES, When? _________________Date

SIGNATURE ____________________________________

PAST MEDICAL HISTORY FORM

Name:____Age:______

Do you have, or have you had a history of any of the following?

_______Stroke
_______Diabetes
_______Arthritis
_______Knee or hip problems
_______Neck problems
_______Osteoporosis
_______Back problems
_______Cancer
_______Heart problems
_______High blood pressure
_______Pacemaker/defibrillator
_______Blood thinner medication
_______Vision problems
_______Respiratory problems
_______Hard of hearing/deafness
_______Other (please explain below)

If so, provide any relevant explanation (i.e. diagnosis, approximate date, any surgery)

____
____
____

Please list any medications you now taking, and the reason why you are taking them:

____
____
____

Please indicate any symptoms you are currently experiencing:

_______Dizziness
_______Vertigo
_______Imbalance
_______Falling or near falls
_______Fear of falling
_______Difficulty walking
_______Decreased leg sensations
_______Headaches
_______Ringing in the ears
_______Nausea
_______Sensation of motion
_______Head pressure/fullness
_______Visual changes

Does your dizziness or imbalance cause you difficulty with doing daily tasks (such as):

________Bending
________Reaching/looking up
________Going up/down steps/curbs
________Walking in the dark
________Walking on uneven surfaces
________Shopping
________Reading
________Showering
________Dressing
________Home or yard care

Date of onset of symptoms (please give an approximate month/year date):________________
Have you ever had these symptoms before?____________If so, when:____________________

Please rate the intensity (on a scale of 0 to 10 with 0 being no symptoms and 10 being the worst possible) if you are dizzy ____________or imbalanced____________. Does it vary?__________.

Have you received any vestibular/balance services from any other agency or program?________
(When, where)____

Have you received occupational or physical therapy or nursing services this past year?________
(when, where)____

Do you participate in any sports, exercise programs or activities on a regular basis? __________

____________________________________ ________________________________

Patient's signature Date Therapist's Signature Date

NAME: ______________________________ DATE: ________________

DIZZINESS HANDICAP INVENTORY (DHI)

INSTRUCTIONS: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or imbalance. Please answer "yes", "no" or "sometimes to each question.

	YES	SOMETIMES	NO	
1. Does looking up increase your problem?				P
2. Because of your problem, do you feel frustrated?				E
3. Because of your problem, do you restrict your travel?				F
4. Does walking down the aisle of a supermarket increase you problem?				P
5. Because of your problem, do you have difficulty getting into or out of bed				F
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, parties				F
7. Because of your problem do you have difficulty reading?				F
8. Does performing more ambitious activities like sports, dancing, household chores, such as sweeping or putting dishes away, increase your problems?				P
9. Because of your problem are you afraid to leave your home without having someone accompany you?				E
10. Because of your problem have you been embarrassed in front of others?				E
11. Do quick movements of your head increase your problem?				P
12. Because of your problem do you avoid heights?				F
13. Does turning over in bed increase your problem?				P
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?				F
15. Because of your problem, are you afraid people may think that you are intoxicated?				E
16. Because of your problem, is it difficult for you to go for a walk by yourself?				F
17. Does walking down a sidewalk increase your problem?				P
18. Because of your problem, is it difficult for you to concentrate?				E
19. Because of your problem, is it difficult for you to walk around your house in the dark?				F
20. Because of your problem, are you afraid to stay home alone?				E
21. Because of your problem, do you feel handicapped?				E
22. Has your problem placed stress on your relationship with members of your family or friends?				E
23. Because of your problem are you depressed?				E
24. Does your problem interfere with your job or house responsibilities ?				F
25. Does bending over increase your problem?				P

Dizziness Handicap Inventory - page 2

Name:____________________________ Date: ________________________

Please rate your Dizziness level with activity:

None 1 2 3 4 5 6 7 8 9 10 severe dizziness

Put a check in the box that best describes you:

☐ Negligible Symptoms

☐ Bothersome Symptoms

☐ Performs usual daily activities but symptoms interfere with outside activities

☐ Symptoms disrupt performance of both usual daily activities and outside activities

☐ Currently on medical leave or had to change jobs because of symptoms

☐ Unable to work for over one year or established permanent disability with compensation payments

Modified Fall Efficacy Scale

Name: ______________________ *Date:* __________________

Instructions: On a scale of 0 to 10, how confident are you that you can do each of these activities without falling, with 0 meaning "not confident/not sure at all", 5 being "fairly confident /fairly sure", and 10 being "completely confident/ completely sure'?
If you have stopped doing the activity at least partly because of being afraid of falling score a 0.
If you don't currently do the activity for other reasons, please rate that item based on how you perceive you would, if you had to do the activity today.

	Not Confident At all					*Fairly Confident*					*Completely Confident*
	0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
1. Get Dressed and Undressed											
2. Prepare a Simple Meal											
3. Take Bath or a shower											
4.Get in/out of a Chair											
5. Get in/out of Bed											
6. Answer the Door or phone											
7.Walk around the inside of your house											
8. Reach into cabinets or closet											
9.Light Housekeeping (dishes, dusting, make bed).											
10. Simple Shopping											
11. Using Public transport- Airports											
12. Crossing roads or parking lot											
13. Light gardening or hanging out the washing											
14. Using front or rear steps											

The Activities-Specific Balance Confidence (ABC) Scale

Patient Name: ______________________________ DOB: __________ Date: ____________

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No confidence -- Completely confident

"How confident are you that you will not lose your balance or become unsteady when you...

1. Walk around the house? ______%
2. Walk up or down stairs? ______%
3. Bend over and pick up a slipper (or item) from the front of a closet floor _____%
4. Reach for a small can off a shelf at eye level? _____%
5. Stand on your tiptoes and reach for something above your head? _____%
6. Stand on a chair and reach for something? _____%
7. Sweep the floor? _____%
8. Walk outside the house to a car parked in the driveway? _____%
9. Get into or out of a car? _____%
10. Walk across a parking lot to the mall (store)? _____%
11. Walk up or down a ramp? _____%
12. Walk in a crowded mall where people rapidly walk past you? _____%
13. Are bumped into by people as you walk through the mall? _____%
14. Step onto or off an escalator while you are holding onto a railing? _____%
15. Step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. Walk on slippery surfaces? _____%

Instructions for Scoring:

The ABC is an 11-point scale and ratings should consist of whole numbers (0-100) for each item. Total the ratings (possible range = 0 – 1600) and divide by 16 to get each subject's ABC score.

Total Score: ____________________