NEW PATIENT INFORMATION SHEET

DATE:______________ EMAIL ADDRESS:____________________________

PATIENT'S NAME:____
LAST FIRST MIDDLE INITIAL

IF PATIENT IS A MINOR, PARENT'S NAME:______________________________

ADDRESS:____
NUMBER & STREET CITY STATE ZIP CODE

PHONE NUMBERS: DAYTIME:___________________ EVENINGS:_________________

DATE OF BIRTH:______________

PRIMARY CARE PHYSICIAN'S NAME, ADDRESS & PHONE NUMBER:

____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Are you presently taking any medication? If yes, please list:
   ____
2. Are you allergic to any medication? If yes, please list:
   ____
3. Are you currently under the care of a doctor for any reason? If yes, please explain:____
4. Have you been hospitalized in the past five years for more than two days? If yes, please explain:____
5. If you have had any of the following conditions, please circle:

Anemia	Cardiac Pacemaker	Heart Trouble	Rheumatic Fever
Arthritis	Convulsions	Hepatitis	Sinus Trouble
Asthma	Diabetes	High Blood Pressure	Stroke
A Blood Disorder	Epilepsy	Jaundice	Tuberculosis
Bleeding Problems	Glaucoma	Kidney Problems	Ulcers
Cancer	Heart Murmur	Psychiatric Treatment	X-Ray Treatment

6. Any other serious illness?______________________________________

SIGNATURE OF RESPONSIBLE PARTY:__________________________

ASSIGNMENT OF BENEFITS

In order for Central Florida Dreamplex to bill Medicaid and/or other insurance for therapy evaluations, treatments or medical equipment, this form must be completed, signed, dated and returned immediately.

Without the signed and dated form on file, we cannot begin evaluation, treatment, or supply medical equipment that is ordered.

I understand by signing this form, that I am authorizing the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental and other insurance benefits to Central Florida Dreamplex and/or any of their corporate affiliates.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurer(s) and their agents and assigns, as needed for the limited purpose of processing payments, treatment, or Central Florida Dreamplex operations.
4. Central Florida Dreamplex and/or any of their corporate affiliations to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for evaluation, treatment, and/or medical equipment provided.
5. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts may include, but are not limited to, co-payments and deductibles.
6. I understand that a verification of benefits will be provided by Central Florida Dreamplex but is not a guarantee of payment as it remains subject to benefit limits, exclusions, and eligibility.
7. Central Florida Dreamplex and/or any of their corporate affiliates to contact me by telephone or mail regarding evaluations, therapies, and/ medical equipment.

BEST CONTACT NUMBER: (____)____________________

Insurance (Other than Medicare/Medicaid):

Insurance Name____________________ Insurance Phone #____________________

Insurance Policy #____________________ Insurance Group #____________________

Insurance Plan #____________________ Name of Insured____________________

Relationship to Patient________________

PATIENT NAME__________________________

SIGNATURE OF PARENT/ADULT PATIENT________________________DATE_________

HIPAA AUTHORIZATION FORM

1. I hearby authorize the use or disclosure of my protected health information as described below:

   PERSONS OR ORGANIZATIONS PROVIDING INFORMATION –
   Central Florida Dreamplex

   PERSONS OR ORGANIZATIONS RECEIVING INFORMATION –
   Primary Care Physician - ______________________________
   NAME AND PHONE NUMBER

   DESCRIPTION OF INFORMATION TO BE DISCLOSED –
   Medical and Billing Information

   DESCRIBE THE PURPOSE OR INTENDED USE OF INFORMATION –
   Therapy Evaluation, Treatment and/or Medical Equipment Provided

2. **COMPLETE THIS SECTION IF HEALTHCARE PROVIDER REQUESTED AUTHORIZATION**
   Healthcare Provider: Will the healthcare provider receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No_____
   Individual: I understand that I get a copy of this form after I sign it. Initials:_____

3. YES, YOU MAY DISCLOSE INFORMATION ABOUT ALCOHOL/SUBSTANCES ABUSE, HIV/AIDS, OR MENTAL HEALTH:
   Yes – Initial_____ or No – Initial_____

4. I understand I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Initial:____________

5. I understand that this authorization will expire on the following date __/__/__ (D/M/YR) or upon goals reached.

6. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Initial:____________

______________________________________ ________________

7. Signature of Patient or Patient's Representative Date

Printed Name of Patient's Representative:______________________________
Relationship to the Patient:______________________________________

352/394-0212
352/241-6361 Fax

P.O.Box120547
Clermont, FL 34712-0

OFFICE COPY

Cancellation/No-Show Policy

There is a policy that maintains that there are allowances of only 3 "no-call, no-show" OR 3 missed appointments within a 4 week time span at Central Florida Dreamplex.
There may be occasions when you cannot keep an appointment and a quick phone call to the scheduled therapist's cell phone will suffice. Please ask your therapist for their cell phone number and keep it handy for such occasions. You can also call the office at (352) 394-0212 and the message will be passed on to the therapist. If therapy is at the Dreamplex, please call (352)404-4085.

Please keep in mind that the therapist needs as much time as possible to re-arrange their schedule if a cancellation is made. As soon as you see that a cancellation will be necessary, please call the therapist directly, or call the office so that the therapist does not make the trip in vain. The travel time and missed appointment cost the therapist personally and Central Florida Dreamplex corporately.

Central Florida Dreamplex reserves the right to bill a $25.00 cancellation fee if treatment is not cancelled in a timely manner (at least 2 hours prior to the schedule time).

Your child's therapy is important and continuity of care is essential to achieving their established goals and to assist in achieving their optimal development.

I hereby acknowledge the receipt of the cancellation policy.

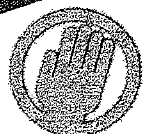
Parent signature ______________________________ Date: ______________________

Childs Name: ______________________________

*****PLEASE RETURN TO OUR OFFICE*****

Thank you,
Central Florida Dreamplex

2400 S Hwy 27 Building B, Suite B201 Clermont, FL 34711.
www.cfldreamplex.com | info@cfldreamplex.com



Central Florida Dreamplex Rules

1) All members, guests, and therapy patients must check-in at front desk at the beginning of each visit.
2) Non-members and siblings of those receiving therapy are not permitted on any equipment and must wait quietly in one of the two waiting areas. All children should be supervised by a parent/caretaker at all times when not receiving treatment.
3) Equipment is for use by registered guests and members only. This area is not supervised.
4) Participation in exercise and fitness programs is done at your own risk. Central Florida Dreamplex is not responsible for any injury that may occur to individuals participating in any exercise activity. Medical clearance before participating is highly recommended.
5) Participants with developmental delays must be supervised at all times. Supervision can come from a parent/guardian, a personal assistant, a therapist, or from an instructor during a class or other program for which the child is enrolled.
6) Closed-top athletic shoes and proper athletic attire is required.
7) Water and sports drinks are permitted provided they are in a sealable non-glass container.
8) Food, gum, tobacco products, smoking, and alcohol are not permitted.
9) Personal effects must be stored where they do not interfere with classes or those using equipment. We are not responsible for any lost or stolen property.
10) The Central Florida Dreamplex reserves the right to refuse service to any member or visitor who violates any rule or regulation, or engages in any verbal and/or physical abuse of staff or other members.
11) A maximum of 6 users are allowed on the rock wall at any given time.
12) No users under the age of 12 are allowed on the rock wall without supervision from a therapist, adult volunteer, or staff member.
13) No users are allowed on any equipment without assistance from an adult therapist, volunteer, or staff member.
14) Only one user per piece of equipment at any time.

I certify that I have received a copy of the Dreamplex Rules and have read and understand them. I hereby waive, release, and discharge Central Florida Dreamplex from any and all liability.

__________________________________ ________________

Parent Signature Date