Stay In Step
Brain and Spinal Cord Injury Recovery Center
10500 University Center Drive Suite 130
Tampa, FL 33612
Phone: 813-977-7999
Fax: 813-977-7444
Email: diosa@stayinstep.org

# Client Application Form

The information obtained in this application will remain confidential. It will be used solely by the staff of the Stay In Step Brain and SCI Recovery Center (SIS) in determining program eligibility.

Patient Last Name: _____First Name: _____Middle: _____

Nickname: _____

DOB: _____ Social Security Number: _____ Gender ___M ___F

Home Address: _____ Apt # _____

City, State, Zip: _____ Telephone Number: _____

May we leave a voicemail message on this number? ___ Yes ___ No

May we speak with someone who may answer this number? ___Yes ___ No

Alternate number for communication: _____

Email address: _____

May we communicate with you via email? ___ Yes ___ No

Do you have an alternate mailing address you prefer to receive communication from us?

Address: _____

Employer Name: _____ Occupation: _____

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**EMERGENCY CONTACT**

Name: _____ Relationship to Patient: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone: _____

**OTHER CONTACT – not living with patient**

Name: _____ Relationship to Patient: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Life Partner ___ Separated ___Widowed

Primary Language: ___ English ___Spanish _____ Other

Ethnicity ___ Hispanic or Latino ___ Non-Hispanic or Latino

Race: ___ American Indian or Alaska Native ___ Asian Indian ___ Asian other
___ Black or African America ___ Chinese ___ Filipino ___ Guamanian or Chamorro
___Hawaiian Native ___ Japanese ___ Korean ___ Multiple ___ Other ___ Pacific Islander
___ Samoan ___ Unknown ___ Vietnamese ___ White

How did you hear about us?
___ Billboard ___ Employer ___ Family member ___ Friend ___ Health Fair ___ Insurance
___ Magazine ___ News ___ Physician ___ Radio ___ Television ___ Website _____ Other

**Medical Information:**

Height: _____ Weight: _____

Date of Injury: _____ Cause of Injury: _____

Level of SCI: _____ Current Rehab Program: _____

Complete/Incomplete: _____

Physician Name: _____ Phone: _____

**Describe your physical abilities**

Upper extremity: _____

_____

_____

Trunk (IE: Can you sit up):_____

_____

_____

Lower extremity: _____

_____

_____

**List any physical problems**

____Yes ___ No Hypersensitivity

____Yes ___ No Osteoporosis/ Osteopenia

____Yes ___ No Pressure Sores/ Skin Breakdowns

____Yes ___ No Heterotrophic Ossification

____Yes ___ No Joint/ Muscle disorder

____Yes ___ No Obesity

____Yes ___ No Knee instability

Briefly describe event(s) leading to the injury: _____

_____

_____

_____

Briefly explain unlisted symptoms: _____

_____

_____

_____

**Medical History:**
Please answer "yes" or "no" for the following. Please answer "yes" to those that apply to you at present or have applied to you in the past, with a brief explanation in the space provided.

| History | Yes | No | Explanation/Frequency |
|---|---|---|---|
| Alcohol | | | |
| Tobacco | | | |
| Diabetes | | | |
| High Cholesterol | | | |
| Chest Pain | | | |
| Hypertension | | | |
| Obesity | | | |
| Muscle Tension | | | |
| Hypothyroidism | | | |

| | | | |
|---|---|---|---|
| Hernia | | | |
| Breathing/Lung Problems | | | |
| Heart Disease | | | |
| Ventilator Dependent | | | |
| Tendon/Joint Problems | | | |

Are you aware of any disease or disorder that would complicate your participation in an intense exercise program? _____

_____

_____

Are you currently involved in any recreational physical activities? _____

_____

Has your physician approved your participation in an intense exercise program?

____Yes ___ No

**NOTE:** Written approval by your physician is a requirement prior to beginning rehabilitative therapy at SIS.

Is there any reason not mentioned here why you should not follow a regular exercise or therapeutic rehabilitation program?

____Yes ___ No

If yes, please explain: _____

_____

Additional comments you feel may be pertinent to the success of your therapy: _____

_____

Number/Date of Last Hospitalization: _____

_____

**Please list all current medications to include dosage, frequency, and function:**

_____

_____

_____

_____

_____

_____

_____

Special considerations: _____

_____

_____

_____

I have completed this application to the best of my knowledge. I understand that if necessary, SIS reserves the right to request medical clearance before beginning any therapeutic exercise program and has the right to deny my participation in the program if requests are not met. I understand that participating in the program at SIS while under the influence of any substance or intoxicated (e.g. marijuana, alcohol, etc.) is strictly prohibited. I also understand that SIS reserves the right to discontinue and/or deny treatment to clients (to include family members, associates, etc.) who are rude, unruly or disruptive.

Client Name: _____ Signature: _____

If under 18, name of parent or guardian: _____ Relationship: _____

Signature: _____ Date: _____

**WAIVER AND RELEASE FROM LIABILITY**

I, _____ , ("Client") hereby agree to release,

indemnify, hold harmless and forever discharge ROMY AND GABY SCI FOUNDATION INC. D/B/A STAY IN STEP BRAIN AND SCI RECOVERY CENTER (the "Company") and its agents, employees, independent contractors, directors, affiliates, successors and assigns, of and from any all claims, demands, contracts, expenses, causes of action, lawsuits, damages, and liabilities of every kind of nature, whether known or unknown, in law or equity, that Client has had or may have, arising from or in any way related to Client's participation in any of the exercises, therapies, events, programs or activities conducted by or on the premises of or for the benefit of the Company. I represent that I am in satisfactory physical condition to participate in the Company's exercises, therapies, events, programs or activities. Client acknowledges that Company's exercises, therapies, events, programs or activities Client participates in will, in many cases, be an extreme test of Client's physical and mental limits and carry the potential for severe physical injury and even possibly death, yet Client agrees to assume all risks involved with participation on such exercises, therapies, events, programs or activities, and waives any liability of Company, waives any right to a lawsuit or claim against Company, and on behalf of Client's heirs, waives all such rights also. Client hereby assumes the risks of participating in all the Company's exercises, therapies, events, programs or activities. Client certifies that Client is physically and mentally able to participate in the Company's exercises, therapies, events, programs or activities and has not been advised otherwise by a qualified medical professional. Client understands that participating in the Company's exercises, therapies, events, programs or activities does not constitute medical treatment, diagnosis or advice. Client understands that Client should seek the advice of a physician or another qualified health provider, if Client has questions about medical condition(s) before beginning Company's exercises, therapies, events, programs or activities. Clients over the age of 60 years old understand that a bone density scan is required prior to participating in Company's programs, and that the bone density scans results will be shared with the Company. Client certifies that in consideration of becoming a client of the Company's programs, Client hereby takes the following action for itself, its executors, administrators, heirs, next of kin, successors and assigns: Client waives, releases and discharges Company from any and all claims or liability for any loss, damage, injury or death of any kind which arise out of or are related to Client's participation in Company's exercises, therapies, events, programs or activities or Client traveling to and from the Company's facilities; including but not limited to: 1) any known and unknown, foreseen and unforeseen body and personal injury, 2) loss of life, and 3) any attorney's fees, costs, expenses, or charges sustained, directly or indirectly, or alleged to have been sustained, or in any fashion, arising from, in connection with, or resulting from its participation in the Company's exercises, therapies, events, programs or activities, even if due to the negligence of the Company or any employee, independent contractor, volunteer, director, officer, client, owner or agent of Company. Client will indemnify and hold harmless the Company and any and all of Company's employees, independent contractor, volunteers, directors, officers, clients, owners and agents thereof from any claim, demand, and/or cause of action of any nature whatsoever, related to the Client's participation in the Company's exercises, therapies, events, programs or activities, even if due to the negligence of the Company, including but not limited to any and all losses, liabilities, damages, costs and expenses (including reasonable attorney fees) arising out of such actions. Client agrees that Client, Client's family members, and any of Client's guests and invitees shall be bound by this agreement and the Company's policies, rules and guidelines. Client agrees that the Company's policies, rules and guidelines may be revised, supplemented, or amended in the sole and absolute discretion of the Company, and that any changes shall become immediately effective upon posting

in the Company's facilities or on Company's website. Client further expressly agrees that the foregoing waiver and release from liability agreement is intended to be as broad and inclusive as permitted by the law of the State of Florida. Client has read this waiver and release from liability and indemnity clause, and agrees that no oral representations, statements or inducements apart from this agreement have been made. The Company makes no warranties or representation, express or implied, other than those set forth herein. IN NO EVENT SHALL THE COMPANY BE LIABLE FOR ANY SPECIAL, INCIDENTAL, ECONOMIC, NON-ECONOMIC, PUNITIVE OR CONSEQUENTIAL DAMAGES. This agreement shall be construed in accordance with the laws of the State of Florida, without regard to the conflicts of law provisions thereof. Any controversy, claim or dispute arising out of or relating to this agreement shall be settled by a single arbitrator, chosen by the Company, who shall formerly have been a judge in Hillsborough County, Florida. The parties agree to abide by all decisions and awards rendered in such arbitration proceedings and agree to waive any right to appellate review of said decision or award. Such decisions and awards rendered by the arbitrator shall be final and conclusive and may be entered in any court having jurisdiction thereof as a basis for judgment and of the issuance of execution for its collections. All such controversies, claims or disputes shall be settled in this manner in lieu of any action at law or equity, provided however, that nothing in this subsection shall be construed as precluding bringing an action for injunctive relief or other equitable relief. The arbitrator shall not have the right to award punitive damage or speculative damages to either party and shall not have the power to amend, alter, or reform this agreement in any manner. IF FOR ANY REASON THIS ABRITRATION CLAUSE BECOMES NOT APPLICABLE, THEN EACH PARTY, FULLY PERMITTED BY APPLICABLE LAW, HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY AS TO ANY ISSUE RELATING HERETO IN ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT OR ANY OTHER MATTER INVOLVING THE PARTEIS HERETO.

I authorize any person connected with Company to administer first aid to me, as they deem necessary. I authorize medical and surgical care and transportation to a medical facility or hospital for treatment necessary for my well-being, at my expense, if any person connected with Company deems this to be necessary, in their opinion.

I HAVE READ THE PREVIOUS PARAGRAPHS AND I KNOW, UNDERSTAND AND APPRECIATE THESE AND OTHER RISKS THAT ARE INHERENT IN THE COMPANY'S EXERCISES, THERAPIES, EVENTS, PROGRAMS OR ACTIVITIES. I HEREBY ASSERT THAT MY PARTICPATION IS VOLUNTARY AND THAT I KNOWINGLY ASSUME ALL SUCH RISKS AND ENTER THIS WAIVER AND RELEASE FROM LIABILITY VOLUNTARILY. I FURTHER UNDERSTAND AND AGREE THAT THIS AGREEMENT SHALL ALSO BE BINDING ON MY HEIRS, ASSIGNS, SUCCESSORS AND ALL OTHER PERSONS WHO MAY CLAIM THROUGH ME.

All notices to the Company shall be mailed (certified or registered, return receipt requested) to ROMY AND GABY SCI FOUNDATION INC. D/B/A STAY IN STEP BRAIN AND SCI RECOVERY CENTER, 10500 University Center Dr., Suite 130, Tampa, FL 33612. If any part of this agreement is held by a court of competent jurisdiction to be void and unenforceable, the remainder of the terms and provisions of this agreement shall remain in full force and effect and shall not be affected.

Client Name: _____

Client Signature: _____ Date: _____

Have you had a recent bone density assessment? Yes _____ No _____

If yes, please attach a recent bone density scan with the doctor's interpretation.

**BONE DENSITY TESTING REQUIREMENTS**

Our new clients over 60 years of age and/or 6 months' post injury/re-injury must have a bone density test (Densitometry or DEXA scan) completed and have the results and doctor's interpretation sent or faxed to us. This result will show us if there is increased risk of fracture due to osteopenia or osteoporosis and determine program viability. It's important that you know this as well for your general health and well-being.

The test should include T scores of the Lumbar spine, Right and Left Hips, Greater Trochanter, and Distal Femur. If you have had a bone test performed in the last 6 months, you don't need to have another one done, but you still need to send or fax us the results. Follow-up requirements for subsequent testing will be determined by these initial test results.

We need to have this report prior to scheduling your initial evaluation appointment. Thank you.

Client Name: _____

Client Signature: _____ Date: _____

**SUPPLEMENTAL PROGRAM PAYMENT POLICIES**

Supplemental Program (Self-Pay Clients Only) Rate = $90 per hour for 2-hour session ($180). Must enroll in auto-pay to qualify.

**OPTION 1**

2-hour therapy session/3 days a week (24 hours/month) = Total $2,160.00/month. Qualifies for 50% supplemental funds payment. Client pays $1080.00/month and receives $1080.00/month supplemental funds.

**OPTION 2**

2-hour therapy session/2 days a week (16 hours/month) = Total $1,440.00/month. Qualifies for 35% supplemental funds payment. Client pays $936.00/month and receives $504.00/month supplemental funds.

**OPTION 3**

2-hour therapy session/1 day a week (8 hours/month) = Total $720.00/month. Qualifies for 25% supplemental funds payment. Client pays $540.00/month and receives $180.00/month supplemental funds.

**OPTION 4**

2-hour therapy session/2 times a month (4 hours/month) =Total $360.00/month. Qualifies for 15% supplemental funds payment. Client pays $306.00/month and receives $54.00/month supplemental funds.

**LOCOMOTOR SATURDAYS**

1-hour session of high-intensity ambulation = $75.00 total payment

All clients are responsible to pay for their chosen treatment option the month **PRIOR** to services being rendered.

Management reserves the right to reduce, increase or cease the Supplemental discount at its discretion. As an in-house courtesy, we allow clients to roll over/reschedule appointments based on scheduling availability. This courtesy is available only to clients that cancel/reschedule **EARLIER THAN** 24 hours prior to their assigned appointment time, regardless of reason for appointment cancellation. Clients that miss or are late submitting payments are subject to a loss or permanently reduced Supplemental monthly discount rate.

*I understand that I am responsible for all copays, deductibles, coinsurance and amounts not covered by insurance. I assign to SIS all insurance payments made for any services provided to me and direct SIS to represent me in any grievances or appeals process related to the payment of services rendered by SIS.*

Client Name: _____

Client Signature: _____ Date: _____

# Physical Therapy Prescription Form

StayInStep

Brain and Spinal Cord Injury Recovery Center

Patient Last Name: _____First Name: _____Middle: _____

Nickname: _____DOB: _____

ICD10 – Diagnosis Code(s): _____ ICD10 – Accident Code(s): _____

Additional Codes: _____

Physician Name: _____ Follow up date: _____

Precautions: _____

Comments: _____

_____ Evaluate and Treat

_____ Other (Specify): _____

I hereby certify that the prescribed Physical Therapy is medically necessary for this patient's plan of care.

_____ _____

Physicians Signature Date

**Physicians, please fax this referral slip to (813) 977-7444. THANK YOU!**