Aaron Mattes Therapy
Medical Center of Sarasota
3920 Bee Ridge Road. Bldg A, Suite C Annex
Sarasota, FL 34233
Phone: (941) 922-3232
Fax: (941) 927-6121

Please Note: **Aaron Mattes charges $150.00 an hour for his services.**

Patient Name:_____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA)

I acknowledge that I have received the attached Privacy Notice

_____ _____
Patient or Personal Representative Signature Date

_____
Printed Name

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

Please answer the following questions to help us protect your privacy:

1) May we leave a detailed message on your answering machine? YES/NO Ph#_____
2) May we leave a message at your place of employment? YES/NO Ph#_____
If the answer to the above questions is NO, please let us know how you wish to be notified by our office.

3) May we release information to anyone other that you? YES/NO (i.e. spouse, child, friend, etc.
If the answer is YES, please list each person:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE

Aaron Mattes Therapy

PATIENT INFORMATION **Date:_____**

PATIENT

Last Name:_____First Name:_____MI_____

____M ____F Date of Birth: ____/____/_____ Age:_____

Home Address: _____ Apt.#_____

City:_____ State:_____ ZIP_____ Phone: _____

Marital Status:___Single ___Married _____Divorced Employment Status:____FT____PT
____Unemployed _____Retired _____Student

Employer_____ Work Phone _____ Occupation:_____

Employer Address_____City_____State_____ZIP_____

SPOUSE or GUARDIAN

Last Name:_____ First Name:_____

Employer: _____ Work Phone: _____
Soc. Sec:_____

EMERGENCY

Last Name:_____ First Name:_____ Relationship_____

Home Phone:_____ Work Phone: _____

How did you hear about our clinic?_____

Referring Physician :_____ Phone#_____

Address: _____City_____State_____ Zip:_____

RESPONSIBLE PARTY for the bill:_____

Relationship to Patient:_____

Home Address:_____City_____State_____Zip_____

Home Phone:_____

Please Note: Aaron Mattes Charges $150.00 Per HOUR for his services

Aaron Mattes Therapy

Patient Information and History

Last Name:_____First Name:_____ MI_____

_____Male _____Female Age:_____

Please check NO or YES for those conditions that apply to you

History of high or low blood pressure?	Y or N	Previous neck or back problems?	Y or N
History of heart or blood vessel disease?	Y or N	Currently have visual/hearing problems?	Y or N
Previous heart attacks?	Y or N	Any sensory disturbances?	Y or N
Previous strokes – CVA?	Y or N	History of cancer? When?	Y or N
Currently have a pacemaker?	Y or N	Any unusual reactions to heat or cold?	Y or N
Diabetes?	Y or N	Any broken bones?	Y or N
Arthritis or any other joint problems?	Y or N	Any allergies? Please list.	Y or N
Presently have any metal implants?	Y or N	OTHER:	

If you have answered yes to any of the above questions, please describe further:

_____

_____

List current medications: _____

_____

List previous hospitalizations/surgeries (especially those within the last 6 months) and diagnosis:_____

_____

_____

Describe your chief complaint or problem requiring therapy services:_____

_____

_____

Describe any prior therapy related to this condition (when, how long and the outcome):

_____

_____

What was your prior activity level, including recreational activities?

_____

_____

Please check if you have started to have difficulty with any of the following functional abilities

__Eating	___Walking with/without assistive device	___Swallowing foods
__Dressing	___Balance	___Swallowing liquid
__Grooming	___Mobility	___Speaking clearly
__Bathing	___Getting from bed to chair	___Expressing needs/wants
__Toileting	___Standing up from bed or chair	

This form was completed by the:

____Patient ____Patient Representative _____ Patient with help from therapist