PHYSICAL THERAPY CENTER
1020 N. GRAND AVE. GAINESVILLE, TX 76240
P: 940-665-3496 F: 940-668-2875

Name: _____ Date: _____
First Last

Address: _____City/State:_____ Zip code: _____

Date Of Birth: _____/_____/_____ Age: ____ SS#: _____

Home #:_____ Cell #:_____ Work #:_____

Patient Employer: _____ Phone #:_____

Address: _____ City/State: _____ Zip code: _____

Are You On Any Type Of Home Health Care? **Yes** / **No** If Yes, What Kind: _____

Date of Onset: _____ Date of Surgery/Hospitalization: _____ MRI/XRAY? _____

If Injured, Explain How:
_____

What Part Of The Body Is Affected:
_____

Referring Physician: _____ Date Of Return: _____

Emergency Contact: _____ Relationship: _____ Phone #:_____

To help us better evaluate your condition, please complete these forms to the best of your knowledge. If you have any questions, please, ask for assistance. Thank you.

Please rate your pain in this scale of 0-10

0 1 2 3 4 5 6 7 8 9 10
no pain **worst pain**

Medical History: (Please check any condition you have a history of. Items not checked are understood to be negative.)

Have you seen anyone else for your **current** problem? Date: _____
( ) Physician/MD ( ) Chiropractor ( ) Podiatrist ( ) Orthopedic Surgeon
( ) Dentist ( ) Neurologist ( ) Osteopath ( ) Physical Therapist

SYMPTOMS: In regards to your **current** condition:

Do you have pins any "pins or needles" or numbness in your extremities?	YES NO
Do you have any weakness in your arms or legs?	YES NO
Do you have any coordination or balance problems?	YES NO
Do you have difficulty walking?	YES NO
Do you experience dizziness or vertigo with a change in position?	YES NO
Do you experience headaches as a result of your current condition?	YES NO

Chief Complaint/Current Condition: _____

( ) HIGH BLOODE PRESSURE	( ) ABNORMAL BLEEDING	( ) BOWEL/BLADDER PROBLEMS
( ) HEART PROBLEMS	( ) ASTHMA	( ) AUTOIMMUNE DISORDER
( ) ABNORMAL HEART RATE	( ) EMPHYSEMA	( ) HEART PALPITATIONS
( ) PACEMAKER	( ) LUNG PROBLEMS	( ) CANCER/TUMERS
( ) THYROID PROBLEMS	( ) DIABETES	( ) ARTHRITIS
( ) CHEST PAIN	( ) HISTORY OF ULCERS	( ) DIZZINESS
( ) SHORTNESS OF BREATH	( ) OSTEOPOROSIS	( ) HEARING PROBLEMS
( ) HIGH CHOLESTEROL	( ) SEIZURES/EPILEPSY	Other: _____

Do you have a history of fractures?	YES NO	Where? _____
Do you have a history of neck/back pain?	YES NO	When? _____
Do you have any metal implants?	YES NO	Where? _____
Do you smoke?	YES NO	How much per day? _____
Do you exercise regularly?	YES NO	How often? _____
Do you have any known allergies?	YES NO	Please list? _____
Are you allergic to latex?	YES NO	
Are you pregnant?	YES NO	

MEDICATION: Please circle Y or N if you are taking any of the following (list names of medications)

Blood Pressure? Y/N	Heart Medication? Y/N	Anti-coagulants? Y/N
_____	_____	_____
Muscle Relaxants? Y/N	Pain Killers? Y/N	Diabetes Medication? Y/N
_____	_____	_____
Steroids? Y/N	Anti-inflammatory? Y/N	Other Medications?
_____	_____	_____

SURGERIES: Please list all surgeries, including dates:

_____

_____

DIAGNOSTIC TEST: Please check test(s) for current problem:
__X-Ray __CT Scan __Blood Chemistry __MRI __Bone Scan __EMG __Bone Density __Ultrasound
Other: _____

BILLING AND PAYMENT POLICIES & PRIVACY PRACTICES

BILLING AND PAYMENTS: If I/minor patient has health insurance, I agree to assign the insurance benefits to Physical Therapy Center for payment of the services and supplies provided to me/minor patient.

I understand that Physical Therapy Center will:

- Bill my/minor patient's primary and secondary insurance companies for the treatment and supplies provided.
- I agree to pay Physical Therapy Center for the balance of any charges not covered by insurance (this includes any deductible, co-payments, and coinsurance), for the full amount of the bill for any services that I receive if I do not have insurance, if my workers' compensation claim, if any, is denied, and regardless of how any legal case I may have is resolved.
- I understand that it is my responsibility to obtain any pre-authorizations or referrals required by my insurance.

MEDICARE or MEDICAID BENEFICIARIES:

- If I am a Medicare or Medicaid beneficiary, I will only be billed for any deductibles, coinsurance, and for services or items provided to me that are not covered by Medicaid.
- I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or Medicaid (Title XIX of the Social Security Act) is correct.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received Physical Therapy Center's Notice of Privacy Practices, and if I wish to obtain another copy, one shall be provided to me.

_____	_____	_____
Signature of Patient	Name of Patient (print)	Date
_____	_____	_____
Parent/Guardian Signature (if patient is a minor)	Name of Parent/Guardian	Date

CONSENT TO TREATMENT, OUTCOME STATEMENT & CANCELLATION POLICY

By signing below I am acknowledging and agreeing to the following:

CONSENT TO EVALUATION AND TREATMENT: I consent to evaluation and/or treatment by the physical therapist, aide, and/or student of me or the minor patient listed below. This may include, but not limited to exercise, hands on treatment, or use of medical tools and devices whose purpose will be explained prior to use. I understand that the provider will take into consideration my/minor patient's conditions and use his or her best judgment for my/minor patient's safety to help achieve the goals for the treatment. I understand that I may stop my request for treatment before any procedure or test.

NO GUARANTEE OF OUTCOME: I understand that no guarantees have been made to me about the outcomes of my treatment.

CANCELLATION/LATE POLICY : We at Physical Therapy Center will make every effort to schedule your therapy appointments at a time that is convenient for you. In the event that you cannot attend a particular scheduled appointment, we ask that you call Physical Therapy Center at least 24 hours prior to that appointment to cancel and/or reschedule that appointment. If you do not call to cancel or do not show for a scheduled appointment, you could be charged a $25.00 fee for a missed appointment.

If you miss 3 scheduled appointment, we reserve the right to discharge you from therapy. In order to resume therapy after such time, you will need to see your physician, obtain another prescription and call us to schedule a re-evaluation.

Also, if you are more than 15 minutes late for your appointment, it will be left to the discretion of you therapist whether or not you will be treated at that time.

I give permission to Physical Therapy Center to contact me at home, my cell, or at my work for any therapy/insurance related issue.

If you have any questions about this policy, please do not hesitate to ask.

Thank you for your cooperation.

_____	_____	_____
Signature of patient	Name of patient (printed)	Date
_____	_____	_____
Parent/Guardian Signature	Name of Parent/Guardian	Date

HIPPA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement and authorization.
In refusing, we will not be able to process your insurance claims so you will be responsible for payment in full of and and all visits.

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare facility.

MY SIGNATURE WILL ALSO SERVE AS A PHI (protected health information) DOCUMENT RELEASE IF I REQUEST TESTING OR TREATMENT RESULTS BE SENT TO ANOTHER DOCTOR/FACILITY IN THE FUTURE.

_____ _____

Please PRINT your name Please SIGN your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouses and any caregivers who can have access to this patient's records)

NAME_____
RELATIONSHIP_____

NAME_____
RELATIONSHIP_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS OR TREATMENT AND BILLING INFORMATION VIA:
_____Cell phone _____Home phone _____Work phone

_____

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____

_____Office Use Only: As Privacy Officer, I attempted to obtain the patient's signature Acknowledgement but did not because:
____It was emergency treatment ___ I could not communicate with the patient ____The patient refused to sign
____The patient was unable to sign because/other reason _____

_____Privacy Officer Signature

Medical Information Release Form

I, for myself, or on behalf of the minor patient listed below, authorize Physical Therapy Center and my or minor patient's treating medical providers to discuss and exchange any and all of my/minor patient's medical information as part of Physical Therapy Center's treatment of me/minor patient. If I am a Medicare or Medicaid beneficiary, I give my permission to the Social Security Administration to give Physical Therapy Center information about my Medicare and Medicaid Services or their designees, information about my care in order to receive payment from Medicare/Medicaid.

- I understand that I may revoke this medical information release at any time by notifying Physical Therapy Center in writing.
- I understand that signing this release is not a condition of treatment.
- A copy of this form, including facsimile, may be used in place of the original.

Please note, the suggestions below are provided for you convenience to create open lines of communication with all individuals participating in your care. Authorizing communication with the entities is optional; you are not required to authorize any of the categories below.

I authorize you to discuss medical billing or appointment information with the following individuals.

Primary Care Physician:_____

Other Physician:_____

Attorney:_____

Family Members:_____

Other:_____