EAST TEXAS
PHYSICAL THERAPY, PLLC

1501 Holiday Dr. Sulphur Springs, TX 75482 Office-903-335-8727 Fax- 903-335-8217

FIRST:_____MIDDLE:_____LAST:_____SEX: [ ] M [ ] F

DATE OF BIRTH:_____ MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED

ADDRESS:_____CITY:_____STATE:_____ ZIP:_____

HOME#:_____CELL#:_____SOCIAL SECURITY NUMBER:_____

EMPLOYER NAME & PHONE: _____

REFERRING PHYSICIAN:_____ PRIMARY PHYSICIAN: _____

WHO MAY WE CALL IN CASE OF AN EMERGENCY: _____

HOW DID YOU HEAR ABOUT US? [ ] FRIEND [ ] DOCTOR [ ] BILL BOARD [ ] FACEBOOK OTHER: _____

BILLING INFORMATION

WAS YOUR INJURY A RESULT OF A **WORK-RELATED INCIDENT** OR DID IT OCCUR WHILE ON THE JOB? [ ] **YES** [ ] **NO**

WAS YOUR INJURY A RESULT OF A **MOTOR VEHICLE ACCIDENT** {MVA)? [ ] **YES** [ ] **NO**

ARE YOU CURRENTLY ENROLLED IN-**HOME HEALTH** OR HAVE YOU BEEN IN THE LAST 30 DAYS? [ ] **YES** [ ) **NO**

DATE OF INJURY, SYMPTOMS OR SURGERY:_____

PRIMARY INSURANCE CARRIER: _____

ID#:_____GROUP#:_____

EMPLOYER NAME FOR THIS INSURANCE:_____

INSURED DATE OF BIRTH:_____ SEX: M OR F

SECONDARY INSURANCE: _____ ID#:_____

GROUP#:_____ EMPLOYER FOR THIS INSURANCE:_____

INSURED DATE OF BIRTH:_____SEX: M OR F

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits to be made directly to East Texas Physical Therapy, PLLC. I understand and agree to allow this office to use the Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care and benefits. I understand that I am responsible for all costs for care regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

PATIENT AND/OR GUARDIAN SIGNATURE:_____DATE:_____

FINANCIAL RESPONSIBILITY AGREEMENT

Please take the time to read and sign the financial responsibility statements to acknowledge your understanding of them. These are intended to provide you with clear understanding of our financial agreements and billing procedures to prevent misunderstandings. If you have any questions regarding these agreements, please let the staff know.

I understand that by signing this agreement, I authorize and consent to services and/or products by East Texas Physical Therapy, PLLC. I understand that I am under the supervision of my attending physician and that East Texas Physical Therapy, PLLC is not liable for any act or omission when following the orders of my physician.

Please initial here _____

I hereby authorize direct payment to East Texas Physical Therapy, PLLC of any Medicare/Medicaid/Insurance benefits otherwise payable to me for East Texas Physical Therapy, PLLC for services or products deemed reasonable and customary.

Please initial here _____

I authorize my insurance company(ies) to provide for an agent of East Texas Physical Therapy, PLLC any and all information pertaining to my insurance benefits and the status of claims submitted by East Texas Physical Therapy, PLLC for services received. I understand that I am responsible to notify East Texas Physical Therapy, PLLC when my benefits/insurance changes.

Please initial here _____

I authorize East Texas Physical Therapy, PLLC to submit claims for payment of services provided to me relative to my medical needs. I recognize that reimbursement may be less than 100% of charges billed. Therefore, I acknowledge and agree to be financially responsible for any balance owing on my account; or, if private pay, for all medical expenses on my account. I will be responsible for non-coverage by HMO Medicare.

Please initial here _____

ALL CO-PAYMENTS ARE DUE AND PAYABLE AT THE TIME OF EACH VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. PAYMENTS MAY BE MADE IN CASH, CHECK, OR BY CREDIT CARD.

I,_____(patient's name), a patient of East Texas Physical Therapy, PLLC acknowledge and agree to the above statements, and understand that a part of all of my care may not be covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

Patient Signature:_____Patient Printed Name:_____

Guardian Signature: _____ Guardian Printed Name:_____

Date: _____ If legal Guardian, Relationship to Patient:_____

HIPAA Agreement

Name:_____ Date of Birth:____ /___/____

Release of Information

( ) I authorize the release of information including the diagnosis, records; examination performed, treatment rendered to me, appointment scheduling, and claims information. This information may be released to:

( ) Spouse:_____

( ) Child(ren):_____

( ) Other: _____

( ) Information is **NOT** to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Contact by calling my:

Home: _____

Cell:_____

Work: _____

If unable to reach me:

( ) you may leave a detailed message
( ) please leave a message asking me to return your call
( ) _____

The best time to reach me is (day)_____between (time)_____

Legal Representative or Patient Signature:_____Date:___/____/____

Name and Signature of Witness:_____Date: ____/____/_____

FINANCIAL POLICY

Review Your "Schedule of Benefits." You should call your insurance company with any specific questions related to your policy relating to outpatient physical therapy benefits. You need to accurately verify and understand your policy's deductible, co-payment, coinsurance, visit limitations, effective annual calendar renewal date, and any pre-authorization requirements. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage, and you are ultimately responsible for the full payment of your bill.

Insurance Information: We need complete and accurate information about your policy. We will submit claims to your health insurance company for you. You are responsible for payment of any deductible, co-pay, and co-insurance as determined by your contract with your insurance company. If your insurance company requires you to have a referral from your primary care physician, you will need to have that faxed to our office or brought with you to your appointment. As a courtesy, we will contact your primary care for the referral, but it is ultimately your responsibility to make sure the referral is issued.

Changes in Coverage: It is your responsibility to inform us of any and all changes of insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by your insurance company.

Worker's Compensation: We will confirm your authorization with your case adjuster or case manager. In the event payment for your claim is denied by your worker's compensation carrier, we will file the claims with your personal insurance policy. If your claim is denied by your personal insurance, you are responsible for the full payment of your bill.

Medicare: All Medicare policy holders have a maximum benefit for outpatient physical therapy services. Effective January 1, 2018 the Financial Limitation is $2010.00 for Medicare Part B Outpatient services.
We will monitor your visits and make you aware as you near the maximum allowed by Medicare. You are responsible to make us aware of any previous treatment you may have had at another facility in the past 12 months.

Secondary Insurance: If you have secondary insurance you must present it at your initial visit. The same policies and responsibilities apply to the use of secondary insurance. You are responsible for the accuracy of the insurance information we use to submit the claim, and you are ultimately responsible for the full payment of your bill.

Payment: If you have insurance, balances will be considered current form the date your insurance pays its portion. After that, the payment is due upon receipt of a statement from our office. We will work with you to set-up a payment plan if necessary, please ask.

Minors: A parent or legal guardian must accompany the minor patient at the time of the initial visit. The parent or legal guardian is responsible for full payment as outlined in the above financial policy. If the parents are separated and both legally responsible for the child, you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

Personal Injury, Liability, Auto, or Involvement of an Attorney: This office does not accept letter of protection from your attorney.

Attendance Agreement

In order to maximize the benefits of therapy, it is very important that scheduled appointments be attended. The consistency of attending therapy sessions gives you the best opportunity to obtain maximum treatment benefit and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and other patients.

In signing this form, you are indicating that you understand the attendance policy and the results of not keeping your appointments. We anticipate that you will adhere to the following:

- I understand that if I arrive fifteen minutes late, I may not receive therapy that day, depending on what the therapist's schedule is and that the appointment can be rescheduled for a time/date that fits within the upcoming schedule
- I understand that three "no-shows", within a treatment plan of care, are grounds for discharge from therapy. The physician or referring provider will be notified of my failure to show for appointments and the resulting discharge from therapy.
- I understand that if my regular therapist is not available, I could be given the option to see another therapist if one is available.

Following these guidelines will greatly assist in maintaining the flow of the clinic and allow clinicians to provide optimal care to all patients.

Patient/Guardian Signature _____ Date _____

PAST MEDICAL HISTORY

Social/Health Habits:

Do you use tobacco products? [ ] **YES** [ ] **NO** If so, how often?_____

Are you pregnant or think you could? [ ] **YES** [ ] **NO**
Do you have a pacemaker? [ ] **YES** [I **NO**
Have you fallen within the past year? [I **YES** [I **NO**

Family History: Please check if your family has ever had any of the following:

Heart Disease _____ Diabetes _____ Arthritis _____ Hypertension ____
Cancer _____ Osteoporosis _____ Stroke _____ Other _____

Medical/Surgical History: Please check if you have ever had or currently have:

Musculoskeletal	Neuromuscular	Cardiopulmonary	Other
__Arthritis (Osteo/Rheumatoid)	__Stroke/TIA	__ Heart Attack	__ Cancer
__Osteoporosis	__ Head Injury	__ Hypertension	__ Diabetes/Hyperglycemia
__Fractures or Broken Bones	__ Parkinson Disease	__ Heart Disease	__ Infections/Infectious Disease
__Low Back Pain or Surgery	__ Fibromyalgia	__ COPD	_____
__Joint Pain	__ Nerve Pain	__ Lung Disease	_____
__Bone or Joint Surgery	__ Seizures	__ Vascular Problems	

Please list all surgeries that you have had and the dates performed:_____

_____

Please list all current medications:

_____

_____

_____

Within the past year, have you experienced any of the following? :

__ Chest Pain	__ Heart Palpitations	__ Shortness of Breath	__ Vision Problems
__ Dizziness	__ Fainting	__ Coordination Problems	__ Joint Pain or Swelling
__ Weakness	__ Loss of Balance	__ Difficulty Sleeping	__ Fever or Chills
__ Loss of Appetite	__ Nausea/Vomiting	__ Difficulty Swallowing	__ Pain at night, not relieved by
__ Bowel Problems	__ Bladder Problems	__ Weight Loss	__ position change
__ Weight Gain	__ Headaches	__ Hearing Problems	Other: _____

Please rate your pain MOST of the time over the past week if:

0 = no pain

10 = worst pain imaginable (emergency room pain)

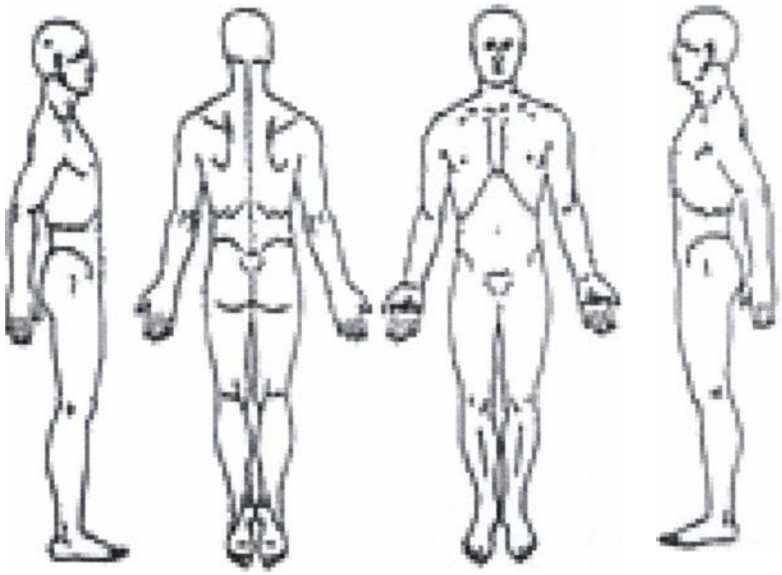
(Circle pain rating below)

0 **1** 2 3 **4** 5 6 7 **8** 9 10

Indicate areas of pain with (/// //) markings below

Indicate areas of numbness/tingling with **(xxxxx)**

Please circle any areas of swelling on the pictures



When did your symptoms occur? What brought them on?

Please list anything you have found that aggravates, or makes your pain/symptoms worse:

Please list anything you have found that eases, or makes your pain/symptoms less:

If you have had any diagnostic tests such as x-rays, MRI, ultrasound, bone scans, etc. that are relevant to this injury, please describe the findings below to the best of your ability.

Thank you for taking the time to complete these forms. Our therapists want to get as much background information on your condition as possible to enable them to give you the best treatment. Once you have completed these forms, please return them to the front office and a therapist will be with you shortly.