EAST TEXAS
PHYSICAL THERAPY, PLLC

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

FIRST: _____ MIDDLE: _____ LAST: _____ SEX: ☐Male ☐Female

DATE OF BIRTH: _____ EMAIL ADDRESS: _____

LANGUAGE SPOKEN MOST OF THE TIME: _____ RACE/ETHNICITY: _____

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? NAME/RELATION: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? ☐FRIEND ☐DOCTOR ☐BILLBOARD ☐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, AND/OR SURGERY: _____

PRIMARY INSURANCE CARRIER: _____ ID#: _____

GROUP#: _____ INSURED DATE OF BIRTH: _____ SEX: ☐Male ☐Female

SECONDARY INSURANCE CARRIER: _____ ID#: _____

GROUP#: _____ INSURED DATE OF BIRTH: _____ SEX: ☐Male ☐Female

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: _____

HIPAA AGREEMENT

Patient's Name: _____ DOB: _____

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): _____
- □ Medical Facility: _____
- □ Other: _____
- □ Information is **NOT** to be released to anyone

This release of information will remain in effect until terminated by me in writing.

Contact me by calling my:

Home Phone: _____

Cell Phone: _____

Work Phone: _____

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) _____ and _____.

Legal Representative or Patient Signature: _____ Date: _____

Name and Signature of Witness: _____ Date: _____

Notice of Privacy Practices Acknowledgment

East Texas Physical Therapy

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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: _____

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? OR Have you ever used tobacco products? □YES □NO If so, how often/long?_____

Are you pregnant or think you could be? □YES □NO

Do you have a pacemaker, defibrillator, or any other implanted devices? □YES □NO

Have you fallen within the past year? □YES □NO

Do you currently eat an altered diet? □YES □NO If yes, explain: _____

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

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

Medical/Surgical History (Please check all that apply):

Musculoskeletal-
□ Osteoporosis
□ Fractures/Broken Bones
□ Lower Back
□ Pain/Surgery
□ Joint Pain
□ Bone/Joint Surgery

Neuromuscular-
□ Stroke/TIA
□ Head Injury
□ Parkinson's Disease
□ Fibromyalgia
□ Nerve Pain
□ Seizure

Cardiopulmonary-
□ Heart Attack
□ Hypertension
□ Heart Disease
□ COPD
□ Lung Disease
□ Vascular Problems

Other-
□ Cancer
□ Diabetes/Hyperglycemia
□ Pneumonia
□ Dysphagia
□ Dementia/Alzheimer's
□ Infections/Infectious Disease
□_____

Surgery/Medications:

Please list all surgeries/dates of surgeries: _____

_____

Please list all current medications: _____

_____

_____

Symptoms (Check all that you are currently experiencing or have experienced within the past year):

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

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

0 = no pain

10 = worst pain imaginable (emergency room pain)

(Circle pain rating below)

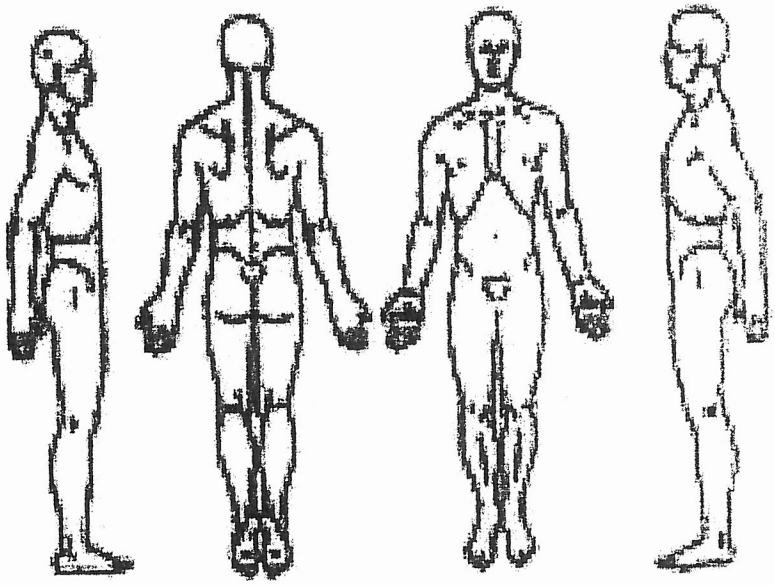
0 1 2 3 4 5 6 7 8 9 10

On the pictures to the right:

Indicate areas of pain with a slash mark (/ / / /).

Indicate areas of numbness/tingling with an x (xxxxx).

Circle any areas of swelling.



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, or other that are relevant to this injury, please describe the findings 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.