North Texas, Terrell, Kaufman Physical Therapy and Rehabilitation Center

LAST NAME_____FIRST NAME_____MI_____

STREET_____APT # _____CITY_____ST_____ZIP_____

HOME#_____CELL#_____OTHER#_____

S.S.#_____DATE OF BIRTH_____MARITAL STATUS_____

EMAIL ADDRESS_____

HOW DID YOU LEARN ABOUT OUR CENTER?
(CIRCLE ONE.) DR. FRIEND EX-PATIENT YELLOWPAGES INTERNET (Where?)_____

CAN WE CONTACT YOU AND SEND REMINDERS VIA: **E-MAIL YES N0 TEXT YES NO**

REFERRING PHYSICIAN_____**PHONE#**_____

EMPLOYER_____ OCCUPATION_____WK #_____

ADDRESS_____CITY_____ST _____ZIP_____

HOW INJURED_____

DATE OF INJURY or SURGERY_____AUTO RELATED? Yes No WORK RELATED? Yes No

HAVE YOU HAD ANY THERAPY THIS YEAR? (CIRCLE) PT OT ST or Chiropractic

IF MEDICARE, ARE YOU RECEIVING ANY TYPE OF HOME HEALTH CARE? Yes No

DO YOU HAVE A NURSE OR AIDE COMING TO YOUR HOME? Yes No Last Date of Service_____

If Yes, Name of Agency_____Phone_____

Dr. prescribing Home Health _____Phone_____

INSURANCE COMPANY_____PHONE #_____

EMERGENCY CONTACT_____PHONE#_____

RELATIONSHIP TO THE PATIENT_____

CONSENT TO TREAT AND ASSIGNMENT OF BENEFITS

The undersigned agrees to be treated by North Texas or Terrell/Kaufman Physical Therapy on an outpatient basis, which includes services rendered under the general and specific instructions of patient's physician or surgeon.

The undersigned hereby assigns to North Texas Physical Therapy or Terrell/Kaufman Physical Therapy all payments for services rendered to patient from any indemnity under the terms of insurance policy or auto insurance to be directly paid to North Texas Physical Therapy or Terrell/Kaufman Physical Therapy upon receipt of an itemized bill from the same. The undersigned understands and accepts financial responsibility for any amount not covered by insurance, except in workers' compensation claims.

SIGNATURE OF PATIENT_____ DATE _____

PRINTED PATIENT NAME_____ DATE _____

SIGNATURE OF RESPONSIBLE PARTY_____DATE_____

NOTICE OF PRIVACY POLICY

A Notice of Privacy Policy describes the uses and disclosure of certain health information. I understand that as part of the provision of healthcare services, this physical therapy group creates and maintains health records and other information describing my health history, symptoms, examination, diagnosis, and treatment. I understand that I have the right to review the notice prior to signing this consent.

_____ _____

Signature Date Relationship to Patient

RELEASE OF INFORMATION

I hereby request and authorize **North Texas, Terrell, Kaufman Physical Therapy and Rehabilitation Center** to release Protected Health Information and/or copies of my medical records pertaining to physical therapy to:

_____

(Agency or Person)

I understand that:

1. Protected Health Information will be released only with due safeguards against abuse and misuse of the information or authorization.

2. This authorization does not authorize release of information by NTPT, TPT, or KPT to any other organization or agency unless I grant further authorization.

3. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without prior written authorization.

4. This authorization shall continue in effect for one year until all insurance payments are final.

_____ _____

Patient's Signature Signature of agent or responsible party for minor or I ncompetent patient

_____ _____

Witness Date

NORTH TEXAS, TERRELL AND KAUFMAN PHYSICAL THERAPY

FINANCIAL POLICY

We appreciate the confidence you have shown in choosing us to provide for your physical therapy needs. This service you have elected to participate in requires a financial responsibility on your part. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We must emphasize that as physical therapy providers, our relationship is with you and not your insurance company. Your insurance is a contract between you, your employer, and your insurance company.

While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We will call to verify benefits and eligibility in order for us to estimate your payment portion. There is no guarantee from the insurance company of their payment amount**.**

We may not know the exact amount due until the claim has been processed, at which time there may be a balance due on your account. In the event that this occurs, we will mail you a statement and we appreciate your prompt payment.

We will accept the contracted rate and the necessary adjustments if we are a participating provider with your insurance. Payment for service is due prior to or upon completion of each treatment visit. We accept cash, checks, Debit Cards, MasterCard, Visa, and Discover.

Non-covered expenses are also your responsibility. We are committed to providing the best treatment for our patients and we only charge what is usual and customary for our area. There may be charges that your insurance company does not cover due to limitations of the policy or what they consider reasonable and necessary. It is your responsibility to know what the policy limits are. Our physical therapists' goal is to improve your condition based on what the doctor and the physical therapist agree is necessary treatment, not on what your policy limits are. Unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

_____ _____

Signature Date Relationship to Patient

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

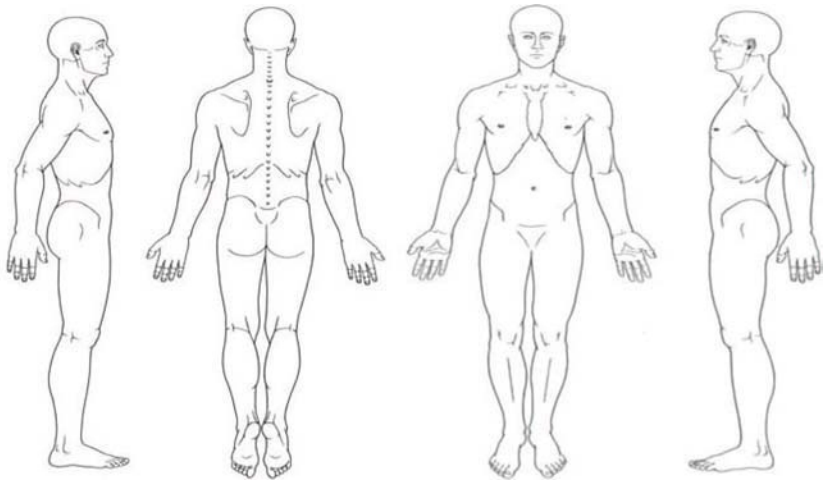
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

---

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

- ☐ Injury as a result of a fall in the past year?
- ☐ Two or more falls in the last year?
- ☐ Patient is at risk for falls?

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ **Currently not taking any medications**

North Texas, Terrell, and Kaufman Physical Therapy and Rehabilitation

Cancellation and No Show Policy

Thank you for making North Texas, Terrell, or Kaufman Physical Therapy your choice for therapy services. **In order to help you, we have found that consistent attendance is the key to our patients' success.**

For this reason, all therapy sessions are important and cancellations/no shows are discouraged. Please take a moment to review the guidelines we have put in place to ensure that you get the most out of your experience at North Texas, Terrell, or Kaufman Physical Therapy:

- **In the event that you will be late for an appointment, please call as soon as possible to notify us of your expected arrival time. Please note that you may be asked to wait until your therapist is available or reschedule.**
- **Please give at least 24 hour notice in the event of a cancellation. If you are unable to give 24 hour notice, please contact us as soon as possible.**
- **It will be up to the discretion of North Texas, Terrell or Kaufman Physical Therapy to charge for repeated cancellations.**
- **No shows <u>will be</u> charged $25 for missed treatment sessions.**
- **Cancellation/No show fees <u>are not</u> covered by insurance and must be paid before services are rendered.**
- **Cancellations due to illness or family emergency are excluded from this policy**.
- **For Worker's Compensation and Auto insurance clients, we are obligated to inform your case manager of any missed treatment sessions.**

I understand North Texas, Terrell, and Kaufman Physical Therapy's Cancellation and No Show Policy and that it is my responsibility to plan appointments accordingly and notify North Texas, Terrell or Kaufman if I cannot fulfill my scheduled appointments.

Patient Signature_____