# Patient Information Form

DATE: _____ ACCT#:_____

NAME: _____ EMPLOYER: _____
ADDRESS: _____ ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ CITY: _____ STATE: _____ ZIP: _____
DOB: _____ MALE [ ] FEMALE [ ] PHONE#:_____
HOME#: _____ CELL#: _____ PRESENTLY WORKING: YES [ ] NO [ ]
SOCIAL SECURITY: _____ OCCUPATION: _____
E-MAIL: _____ MARITAL STATUS: S M D W
ELIGIBLE FOR MEDICARE: YES [ ] NO [ ]

WOULD YOU LIKE TO BE CONTACTED VIA TEXT MESSAGE? YES [ ] NO [ ]
EMERGENCY CONTACT: _____ PHONE#:_____
HOW DID YOU HEAR ABOUT US? _____

## INJURY INFORMATION

WORK RELATED INJURY? YES [ ] NO [ ] MOTOR VEHICLE ACCIDENT? YES [ ] NO [ ]
DATE OF DISCOMFORT: ____/____/____ PREVIOUS PHYSICAL THERAPY? YES [ ] NO [ ]
MEDICAL CARE IN THE HOME? YES [ ] NO [ ]

## INSURANCE INFORMATION (for office use only)

***PRIMARY INS:*** _____ POLICY HOLDER'S NAME: _____
ADDRESS: _____ POLICY HOLDER'S DOB: _____
CITY: _____ STATE: _____ ZIP: _____ POLICY HOLDER'S EMPL: _____
PHONE NO: _____ RELATIONSHIP TO PATIENT: _____
POLICY #:_____ GROUP #: _____
EFFECTIVE DATE: ____/____/____ DEDUCTIBLE: _____ OOP: _____
VERIFIED BY: _____ REFERRAL/ AUTH# :_____ VISITS ALLOWED:_____
INSURANCE: _____% PATIENT CO-INS: _____% PATIENT CO-PAY: $_____

***SECONDARY INS:*** _____ POLICY HOLDER'S NAME: _____
ADDRESS: _____ POLICY HOLDER'S DOB: _____
CITY: _____ STATE: _____ ZIP: _____ POLICY HOLDER'S EMPL: _____
PHONE NO: _____ RELATIONSHIP TO PATIENT: _____
POLICY #:_____ GROUP #: _____
EFFECTIVE DATE: ____/____/____ DEDUCTIBLE: _____ OOP: _____
VERIFIED BY: _____ REFERRAL/ AUTH# :_____ VISITS ALLOWED:_____
INSURANCE: _____% PATIENT CO-INS: _____% PATIENT CO-PAY: $_____

**REFERRING PHYSICIAN:** _____ **DIAGNOSIS CODE: 1.** _____
**NPI:** _____ **2.** _____
**RX DATE:** _____ **THERAPIST:** _____ **3.** _____

# Health History Questionnaire

**In order to provide you with the highest level of personal clinical care, we kindly ask for you to complete this health history questionnaire.**

Name: _____ DOB:_____ Date:_____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: Height: Weight:
Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No
Do you smoke? Yes No Do you have a pacemaker? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

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**Have you RECENTLY noted any of the following (check all that apply)?**

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

**Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?**

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

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**Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):**

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____

Have you ever taken steroid medications for any medical conditions? **YES NO**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

**Please list any surgeries or other conditions for which you have been hospitalized, including dates:**

1. _____ 2._____ 3._____

**What date (roughly) did your present symptoms start?**_____

**What do you think caused your symptoms?** _____

**My symptoms are currently:** ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

**I should not do physical activities that might make my pain worse:** ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

**Treatment received so far for this problem (chiropractic, injections, etc)** _____

**Please list special tests performed for this problem (x-ray, MRI, labs, etc)** _____

**Have you ever had this problem before:** ❑ **Yes** ❑ **No When**_____ **Treatment rec'd**_____

**How long did it take for you to feel better?** _____

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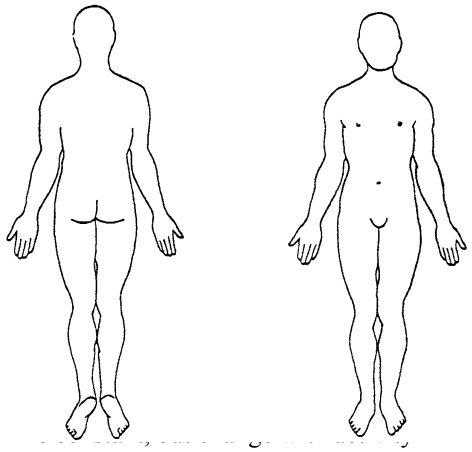
**Body Chart:**

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



**My symptoms currently:** ❑ Come and go ❑ Are Constant ❑

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**Aggravating Factors:** Identify up to 3 important positions or activities that make your symptoms worse:
1. _____
2. _____
3. _____

**Easing Factors:** Identify up to 3 important positions or activities that make your symptoms better:
1. _____
2. _____
3. _____

**How are you currently able to sleep at night due to your symptoms?**
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

**When are your symptoms worst?** ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
**When are your symptoms the best?** ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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**Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:**

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____
**Thank you for participating in your physical therapy care!**

# FINANCIAL POLICY

Thank you for choosing our practice for your physical therapy needs. In order to establish excellent communication and avoid any misunderstanding, we have put together our financial policies for your review.

## INSURANCE:

As a courtesy to our patients, we will provide you with an itemized statement for patient reimbursement; or we will submit insurance claims for you, at no charge, provided you have given us the complete information of your insurance including policy/claim numbers and any other information necessary to expedite your claim. Please understand that this is a courtesy. You are still responsible for any charges incurred. This may include any balance left that your insurance does not cover. You will be expected to pay the amount that your insurance does not cover at each treatment. You will also be asked to assign benefits to us or our billing entity so that payment will be made directly to our office.

## INSURANCE PERCENTAGES:

Each time you come in after you have finished your treatment for the day, we kindly ask that you stop by the reception desk to make sure you have paid any percentages owed for that day's treatment.

## INSURANCE CO-PAYS:

If your insurance plan requires you to pay a co-pay, the co-pay must be paid before treatment is administered.

## DOUBLE INSURANCE:

If you are insured with two or more insurance companies, we will submit claims to your primary and secondary insurance carries only at no cost, provided you bring is the Explanation if Benefits or EOB from the primary carrier after they have paid so that it can be sent to your secondary insurance. If you have met all deductibles required by your insurances and your supplement plan coordinates benefits with your primary insurance, no money will be collected at the time of your treatment; you are responsible for the balance left if, for some reason the insurance company does not cover the total charges.

## MEDICARE:

We do accept assignment on Medicare claims. This means that we will use Medicare's fee schedule when billing for services. Medicare will pay 80% of the charges and you will be responsible for the 20% balance, which we

collect at the end of each treatment. You will be treated only with what we understand to be Medicare acceptable procedures. There is still the possibility that Medicare will not accept all or a portion of your treatment. In that case, you will be given a written notice. At that time, you can decide whether to continue with your treatment or not.

## MEDICARE AND SUPPLEMENTAL INSURANCES:

We do accept assignment on Medicare claims. You will not have to pay a percentage at the time of your treatment providing all deductibles are met and your supplemental plan covers the 20% Medicare does not pay; however you are responsible for any percentage balance not paid by your supplemental insurance(s).

## REFUNDS:

Refunds are not given until the financial balance has been paid in full.

## WORKER'S COMPENSATION:

We accept worker's compensation claims provided it has been by the workers compensation insurance carrier. If false information is given and it proves not to be a worker's compensation claim, you will be responsible for any charges incurred.

## LEGAL CASES:

Whether represented by an attorney for either a work related injury, motor vehicle accident or any other reason, the patient is still responsible for charges incurred, If you have group health insurance, we would prefer you file under that carrier instead of waiting until your claim is settled by your attorney or insurance.

## THANK YOU

We thank you for you for choosing our practice for your physical therapy needs as well as your cooperation with our financial policies. Please feel free to discuss any questions with us either by phone or in person at our client relations desk prior to your initial visit.

Along with lasting results, our goal is to give you the best overall physical therapy experience from the moment of first contact until the last day of your physical therapy treatments.

I _____ voluntarily consent to abide by these financial policies. I am aware that I will be responsible for any balance not covered by my private or commercial insurance.

Patient, POA, Parent or Guardian Signature_____

Date_____

# Physical Therapy Consent For Treatment

I voluntarily consent and authorize the clinical staff of Tier 1 Physical Therapy and Sports Medicine to evaluate, administer, perform and carryout any and/or all procedures ordered by my referring physician or my dependent's referring physician in addition to being determined appropriate by the treating physical therapist. I understand that all care will be administered by or directly supervised by a Texas Licensed Physical Therapist. I understand that any information I choose to withhold may adversely affect my treatment rendered. I understand that there is no guarantee as to the results of the treatment rendered. I agree to participate in my physical therapy treatment program as an active participant. I also understand I will be given the opportunity to discuss any questions or concerns I have in regard to my treatment with the treating licensed physical therapist.

Patient, POA, Parent and/or Guardian

Date