Conroe
Phone: 936.494.1292
Fax: 936.521.2299

PHYSICAL THERAPY ASSOCIATES

Huntsville
Phone: 936.294.0283
Fax: 936.294.9878

Patient Information

PLEASE PRINT LEGIBLY IN BLUE OR BLACK INK ONLY Date of First Visit: _____/_____/_____@ _____

Name _____SSN #_____
Last *First* *MI*

Mailing Address_____ City_____

State_____ Zip code _____ Sex ☐ Male ☐ Female DOB_____/_____/_____

Primary Phone #_____ Email _____

Work/Secondary # _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact Name_____ Relationship _____

Emergency Contact # _____ Ordering Physician _____

Diagnosis_____ ☐ Surgery ☐ Left ☐ Right

How Did You Hear About Us? (Circle each one that applies)

website ● social media ● mail out ● prescribing doctor ● radio ● newspaper ● magazine ● T-shirt

I am a previous patient ● Friend or Family (name optional) _____

Physical Therapy Appointment Reminders

☐Yes, I would like to receive Physical Therapy Associates appointment reminders
☐By Text Message_____ ☐By Phone Call _____
☐No, I would not like to receive appointment reminders.

Family Medical Leave Act

If you are currently on FMLA please fill out the following information.

Date last worked _____/_____/_____ Date planning to return to work _____/_____/_____

Patient Employed by _____ Occupation _____

Medicare Patients

If you are a Medicare Subscriber please fill out the following information.

1. Have you received physical therapy at another facility in the past year? ☐Yes ☐No
2. Are you currently receiving home health? ☐Yes ☐No

If yes, what facility? _____ For how long? _____ What Condition? _____

Please be aware, that if you are currently receiving Home Health Services, you may either be required to discontinue Home Health Services or Outpatient services. If you continue with both, you may be responsible for the charges incurred at our facility. I have read and understand the above.

Patient Signature _____ **Date** _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ (Name of Insurance Co.) and assign directly to Physical Therapy Associates all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Physical Therapy Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature **Relationship** **Date**

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Conditions of Treatment and/or Admission

CONSENT FOR TREATMENT/ ADMISSION

I,_____, hereby authorize the Physical Therapist(s) in charge of my care and Physical Therapy Associates to administer and perform such diagnostic studies and or procedures as the physician(s) deems necessary for diagnosis and treatment.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I am aware that the Notice of Privacy Practices is in a binder in the lobby for my review and understand that I can request a copy from the receptionist.

CANCELLATION AND NO-SHOW POLICY

Physical Therapy Associates reserves the right to charge a **$60.00** fee for appointments broken or cancelled without a *24 hour prior notice*. We also reserve the right to discharge any patient with 2 or more no-shows or cancellations during the prescribed course of treatment as ordered by the patient's physician. If your therapy will be paid for by Worker's Comp, auto insurance, or an attorney, please be aware that cancellations or no-shows indicate your therapy is not necessary and may limit your benefits.

PAYMENT GUARANTEE

I hereby guarantee payment of my portion due to Physical Therapy Associates at the time that services are rendered, unless other arrangements have been made in advance. The patient's total account is due in full at discharge, with allowance made for insurance coverage approved, and assigned to Physical Therapy Associates prior to dismissal.

PATIENT OATH

Physical therapy treatments involve procedures that at times give instant relief and other times may be uncomfortable. I voluntarily make a commitment to be compliant with my home exercise program as well as instructions given to me by my Physical Therapist here in this clinic. I understand that the best results are obtained when I am consistent with my therapy requirements.

Our staff understands your rehabilitation is your top priority. We will to strive to provide the best care possible every time you walk in the door. We will treat you like an individual, not a number, and attempt to exceed your every expectation.

_____ _____ _____

Signature **Relationship** **Date**

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MEDICAL HISTORY FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Reasons for being referred to physical therapy:

_____

_____

2. Check all of the following medical conditions that you have had.

- ☐ AIDS/HIV
- ☐ Blood Illnesses (Anemia, other)
- ☐ Drug/Alcohol Abuse
- ☐ Motor Vehicle Accident
- ☐ Osteoporosis/Osteopenia
- ☐ Kidney/Liver Disease
- ☐ Seizure Disorders
- ☐ Diabetes, type ___
- ☐ Arthritis (OA, RA, other)
- ☐ Respiratory Illnesses (Asthma, COPD, other)
- ☐ Mental Health Issues (PTSD, Anxiety, other)
- ☐ Cancer, If yes, type _____
- ☐ Gastrointestinal Illnesses (Crohn's, IBS, other)
- ☐ High Blood Pressure, normal range ____/____
- ☐ Cardiac Illnesses (CHF, CHD, MI, other)
- ☐ Swelling Issues (PVD, lymphedema, other)
- ☐ Fainting
- ☐ Fractures
- ☐ Glaucoma
- ☐ Stomach Ulcers
- ☐ Hepatitis, type ___
- ☐ Stroke, TIA
- ☐ Herpes
- ☐ Thyroid Disease

3. List any operations or surgeriesthat you have had:

_____ Date:_____

_____ Date:_____

_____ Date:_____

4. List or attach a copy of any medications you are currently taking:

_____

_____

_____

5. List any allergies (seasonal or drug) and describe any drug reactions:

_____

_____

_____

6. Please check the following that you may have or wear.

☐Glasses/Contacts ☐Dentures ☐Pacemaker/cardiac link ☐Metal/ Foreign object Impact

7. Are you pregnant? ☐ Yes ☐ No
8. Any significant weight gain/loss in the last year? (+ --) _____ Lbs. ☐ Yes ☐ No
9. Are you under the care of any other medical/health provider or physician? ☐ Yes ☐ No

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.

_____ _____ _____

Signature **Date** **Print Name Here**

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WEIGHT LOSS or NUTRITION SUPPORT

Excess **weight can** strain your joints and bones and lead **to** musculoskeletal issues including arthritis in the hips, knees and ankles. **Weight** gain **can** also lead **to** lower back **pain** from conditions like herniated discs and pinched nerves from the added pressure on your spine. Additionally, eating the wrong foods can increase inflammation in your body and therefore increase pain. If you would like to talk to our specialist about either weight loss and/or nutritional improvement, check the box below and we will contact you.

☐ Yes!

ACCIDENT INFORMATION
(Attorney Patients Only)

Patient Name _____

Is your visit to this clinic a result of an accident or injury? ☐ Yes ☐ No

Date of Injury_____/_____/_____

If "yes", please give an explanation.

_____

_____

_____

_____

_____

Complete this portion only if the injury is the result of an *AUTO ACCIDENT*

Please list your Attorney's Information

If you have an attorney who is representing you in this automobile accident please list the following information in the event records are requested. Thank you.

_____
Name of Attorney

_____
Name of Law Firm

_____ _____
Phone Number Case Number

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HIPAA

Health Information Portability and Accountability Act

I am aware that a copy of the HIPPA (Health Information Portability and Accountability Act) is available for my review in the lobby of Physical Therapy Associates; as pertains to my treatment.

1. I authorize clinic staff at Physical Therapy Associates to release my private medical information to all medical sources involved in my care, including insurance health plans, physicians, health care professionals, hospitals, clinics, laboratories, pharmacies, medical facilities, or other healthcare providers that have provided payment, treatment or services to me or on my behalf.

2. **SOCIAL MEDIA/ONLINEAUTHORIZATION - Check One:**

☐**YES**– I authorize the use and disclosure of my pictures, videos etc. on Social Mediaor online for marketing & advertisement purposes; (name, photo or video image, and/or testimonial)
This photo/video authorization remains in effect for 99 years from the date signed.

☐**NO** – I do not authorize the use and disclosure of my pictures, videos etc. on Social Media or online.

3. If we identify that you have missed an appointment time or you are not scheduled for future appointments per your treatment plan, we will call the phone numbers(s) you have provided. Please list any phone numbers YOU ***DO NOT*** WANT US TO LEAVE A MESSAGE ON. _____

4. On occasion we have phone calls from patient's friends and family members regarding their appointment times or general condition. Please list the names of any people you ***DO NOT*** want our facility to give this information to.

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand these authorizations and or exclusions will remain in effect until such time I request, in writing and is received by the practice by registered mail, that these be revoked. Revocation affects disclosures moving forward and is not retroactive. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____
Signature of Individual or Individual's Legal Authority **Date**

_____
Printed Name

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Welcome!

Thank you for choosing *Physical Therapy Associates* to be a part of your healing process. The guidelines listed below are intended to make your appointments more comfortable for you. If at any time during the course of your treatment you do not feel cared for or feel your treatment is not providing the desired improvement, please let your Therapist know.

HOW TO BE A SUCCESSFUL PATIENT

Commit 100%! Be willing to do what is required of you in the clinic and at home. Your physician prescribed therapy for you. If they want you to attend 3 sessions per week make sure you attend them all. Your PT has eyes in the back of their head and will know when you have been cheating yourself at home and in the clinic.
Create a healthy lifestyle! Eat before your sessions. Produce good sleep habits. Laugh, it's a natural antidepressant.
Tips to exercising at home: Some of the exercises given to you can be done while sitting, watching TV or while standing at the sink. Have a family member hold you accountable for completing your exercises. Try doing some stretches before getting out of bed in the morning.

CLOTHING GUIDELINES

Physical Therapy involves performing exercises to improve your condition. If your injury involves your arm, neck or shoulder, a sleeveless shirt will allow the staff easy access.If your injury involves your lower back or leg, shorts will be the most comfortable attire. For aquatics, no cutoff shorts. Bathing suits or athletic attire are acceptable. T-shirts & shoes are optional.

Feel free to use our restroom to change into different clothing if that works best for you. We do ask that a shirt be worn at all times while on land during your treatment (unless specified to do otherwise from your provider).If you are uncomfortable being around other patients during your treatment, we can offer a curtained treatment table for your privacy. Please inform your therapist.

SCHEDULING APPOINTMENTS

If there are specific times that work best for you to schedule, please schedule a minimum of one week's appointments in advance to assure you can receive your desired time slot.It is important to attend your appointments so that you receive the maximum number or treatments prescribed to you by your physician and agreed upon by your therapist.

If you need to cancel an appointment, please notify the receptionist 24 hours in advance Physical Therapy Associates reserves the right to charge a $60.00 fee for appointments broken or cancelled without a *24 hour prior notice* so please CALL US in advance to cancel. *Our automatic phone reminder system does not accept text messages*. If you schedule a "make-up" appointment for that week you can avoid the fee. Call (936)294-0283

If you are required by your insurance company to pay for a portion of your treatment, we ask that you pay the day services are rendered.

Welcome to the family!