ATHENS PHYSICAL THERAPY

907 S. PALESTINE ATHENS , TX 75751

PH 903.675.0077 FAX 903.675.0078

EMAIL: PTATHENS@YAHOO.COM

PATIENT INFORMATION

NAME:______________________________ LAST 4 SS#__________ DOB:______________

ADDRESS:____________________________ CITY:______________ STATE:____ ZIP:______

SEX: Male___ Female:___ Married__Single__Divorced__Widowed__

Primary Ph:______________ Alt Ph:______________ Email:______________________

Spouse/Parent:______________________ DOB:____________ Ph:__________________

ALTERNATE EMERGENCY CONTACT:______________ *Relationship*__________ *Ph:*________

How did you hear about us?____

Referring Physician:__________________ Primary Physician____________________

EMPLOYMENT:

EMPLOYED-FULL TIME_ EMPLOYED-PART-TIME__ RETIRED__ FULL TIME STUDENT__ OTHER__

Employer:______________________________ Occupation:______________________

Employer'sAddress:______________________________________ Ph:______________

INJURY DETAILS:

Date of injury:____________________ State where injury occurred:______________

Injury Details:____

Do you have an Attorney?_______ Name of Attorney:__________________________

Work related injury?________ If yes, EMPLOYER at the time of injury:____________

Employer's Address:____

City:______________________ ST:____________ Zip:______________ Ph:__________

GUARANTOR/RESPONSIBLE PARTY (Person listed on Insurance Card)

Same as Patient__ Spouse__ Parent__ Other__

Name:______________________________ LAST 4 SS#___________ DOB:______________

Address:__________________________ City:______________ ST:__________ Zip:____________

SEX: *Male__ Female__ Relationship to Patient:*__________________________ Ph:____________

I hereby assign, transfer, and set over to Athens Physical Therapy GBC,LLP, DBA Athens Physical Therapy all of my rights, title and interest to any medical reimbursement benefits under my insurance policy. I authorize the release of medical information needed to determine those benefits. I expressly authorize the release of information (if any) pertaining to HIV/AIDS testing & the treatment, mental health, drug abuse, or sexually transmitted diseases. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature of Parent/Responsible Party:__________________________ Date:________

ATHENS PHYSICAL THERAPY

REGARDING PATIENT PRIVACY

Name:______________________________ **DOB:**____________________

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. My insurance company);
- The day to day health operations of your practice.

This acknowledges that I have been notified of your HIPAA Patient Privacy Policy (revised September 2013) and that I was given the option to receive a paper copy, or review the "waiting room" copy. I understand that you reserve the right to change the terms of this notice from time to time . I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations. But you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Information may be released to :

Name:____________________________ **Relation:**______________________

Name:____________________________ **Relation:**______________________

Name:____________________________ **Relation:**______________________

PATIENT SIGNATURE:____

PRINT PATIENT NAME:_______________________________________

DATE:____

ATHENS PHYSICAL THERAPY

Assignment of Benefits/Authorizations to Release Information

I request that payment of authorized Medicare, Medicaid, or Private Insurance Benefits be made to Physical Therapy of Gun Barrel City LLP,Athens Physical Therapy, for any covered services furnished by Physical Therapy of Gun Barrel City LLP/Athens Physical Therapy. I agree to pay to Physical Therapy of Gun Barrel City LLP./Athens Physical Therapy, the deductible and /or co insurance on my claim.
I authorize the release of medical information needed to determine insurance benefits.
I further certify that the information provided by me is true,accurate and complete.
I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and /or co-payment amounts, all deductibles,any amount that exceeds benefits limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

CONSENT FOR TREATMENT

I understand my physician has referred me (or my child) for physical therapy evaluation and development of a PT PLAN OF CARE. I hereby give my consent for evaluation and treatment using standard PT evaluation techniques.

ATTENDANCE POLICY

Keeping each appointment is vital to the progress you will make. In an effort to accommodate all of our patients,advance notice is required if you anticipate being late, or need to change or cancel any therapy appointments for any reason. Our policy regarding appointment that must be cancelled or changed is as follows:
Cancellation: These are defined as appointments that are canceled in advance of the appointment time. If 50% of appointments are cancelled over a two- week period, your therapy services may be discontinued.
Late: If you are more than 15 minutes late, it may be necessary to cancel and reschedule your appointment. Please feel free to call us if you are going to be late, and we will let you know if we need to reschedule your appointment.
No Show: These are defined as appointments that are missed without calling or notifying our office in advance. Three(3) NO SHOW's may result in immediate discharge from therapy services.

PATIENT RESPONSIBILITY

**I am responsible for co-insurance and /or deductible per my insurance. Each visit, I will be responsible for a GOOD-FAITH PAYMENT as an estimate of what is due. I understand that my good-faith- payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance.

GOOD FAITH ESTIMATE: ______________________________ **/PER VISIT**

___Zero due at visit. We will bill insurance and bill you if there is any remaining balance due.

______________________________ ______________________

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**

____

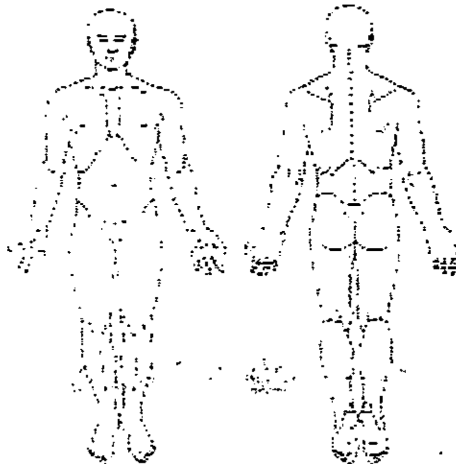
RELATIONSHIP TO PATIENT

MEDICARE PATIENTS:
Have you **ever** received outpatient physical therapy? ___yes ___no
How long ago:_______________
Are you **currently** receiving home health services? ___yes ___no
Name of Home Health:___________
Have you received **Home Health services in the last 30 days?**___yes___no
Name of agency:___________

Athens Physical Therapy

Patient Name:____________________________DOB:____________Age:____

Injury or Onset Date:____________________
(If you do not recall the exact date, please list the most recent occurrence of your problem.)
History of this present condition-(How did this get started):________________________________
____
Your chief complaint/primary concern:____
On the body diagram below,please indicate where your pain is located at the PRESENT time.



Before your problems started, did you have any problems with your normal daily activities, and if so,what?____
Current problems you may be having:

- Standing &/walking___yes__no Describe:______________________________
- Carrying or handling objects__yes__no Describe:_________________________
- Moving your head or neck__yes__no Describe:___________________________
- Changing position__yes__no Describe:_________________________________
- Self Care(i.e.,bathing,grooming,dressing)__yes__no Describe:_______________
____

Have you had an X-ray , MRI, or other imaging study for this problem?__yes__no

PAIN SCALE

0 = NO pain   10 = Worst pain imaginable

Worst	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

Past Medical History: Please circle each condition that you have been told you have (or had):

Cancer	Diabetes	Kidney Disease	Liver Disease	High Blood Pressure	
Stroke	Heart Disease	Angina/Chest Pain	Lung Disease	Fibromyalgia	Incontinence
Osteoporosis	Osteoarthritis	Ulcers	Asthma/Allergies	Hepatitis	Rheumatoid Arthritis

Do you have a PACEMAKER OR DEFIBRILLATOR?___YES____NO

Have you had a recent illness? If yes,please explain:____

Do you take blood thinners?__yes__no Are you allergic to latex?__yes__no

Other:____

____

Fall History: History of falls in the Past 12 Months?__YES__NO IF YES,How many times?___________

Did you hurt Yourself?____

____

Complete Past Surgical History(List & Date):

____

____

____

____

____

____

____

List All Current Medications:

____

____

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____

____

What are YOUR personal goals following completion of therapy?

____

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