PHYSICAL THERAPY ASSOCIATES
Sports & Orthopedic Specialists

Patient Name: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cellular Phone: (_____) _____-_____

I wish to be contacted by: ☐ Text ☐ Email ☐ Phone for: ☐ Appt reminders ☐ Newsletters / PT Promotions

Email Address: _____

Social Security #: _____/_____/_____ ☐ Male ☐ Female Date of Birth: ____/____/_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

Employer Name: _____ Work Phone: (_____) _____-_____

Employer Address: _____City: _____ State: _____ Zip: _____

Spouse: _____ Work Phone: (____) _____-_____

Emergency Contact: _____ Phone: (____) _____-_____

ACCIDENT INFORMATION

Date of Onset: _____ Surgery Date: _____ Referring Dr: _____

Type of Accident: ☐ Worker's Comp ☐ AUTO ☐ NONE ☐ OTHER: _____

Details of accident or how problem began: _____

_____

INSURANCE INFORMATION

Insurance Name: _____ Insurance Phone: _____

Insurance Address: _____

Policy/Claim #: _____ Group #: _____

Insured Name: _____ Insured SS#: _____

Insured Birthdate: ____/____/____ Address: _____ City: _____ State: ___

Insured Employer: _____ Insured Phone #: _____

Are you currently taking any prescriptions or non-prescription medications? YES NO

- ❑ Anti-Inflammatories_____
- ❑ Muscle relaxers _____
- ❑ Pain Medication _____
- ❑ Other _____

Have you had any of the following for this Injury/Episode?

	YES	NO		YES	NO
Chiropractor	❑	❑	CT Scan	❑	❑
EMG/NCV	❑	❑	General Practitioner	❑	❑
Massage Therapy	❑	❑	MRI	❑	❑
Discogram	❑	❑	Neurologist	❑	❑
Occupational Therapy	❑	❑	Orthopedist	❑	❑
Physical Therapy	❑	❑	Podiatrist	❑	❑
Emergency Room (ER) care	❑	❑	X-Rays	❑	❑

*Which ER? ❑ Covenant ❑ UMC ❑ Other: _____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	❑	❑	Severe or Frequent Headache	❑	❑
Shortness of Breath/Chest Pain	❑	❑	Vision or Hearing Difficulties	❑	❑
Coronary Heart Disease or Angina	❑	❑	Numbness or Tingling	❑	❑
Do you have a Pace maker?	❑	❑	Dizziness or Fainting	❑	❑
High Blood Pressure	❑	❑	Ringing in your ears?	❑	❑
Heart Attack or Heart Surgery	❑	❑	Weakness	❑	❑
Stroke/TIA	❑	❑	Weight Loss/Energy Loss	❑	❑
Blood Clot/Emboli	❑	❑	Hernia	❑	❑
Epilepsy/Seizures	❑	❑	Tuberculosis	❑	❑
Thyroid Trouble/Goiter	❑	❑	Allergies	❑	❑
Anemia	❑	❑	Any Pins or Metal Implants	❑	❑
Bowel or Bladder Problems	❑	❑	Joint Replacement	❑	❑
Diabetes	❑	❑	Neck Injury/Surgery	❑	❑
Cancer or Chemotherapy/Radiation	❑	❑	Shoulder Injury/Surgery	❑	❑
Arthritis/Swollen Joints	❑	❑	Elbow/Hand Injury/Surgery	❑	❑
Osteoporosis	❑	❑	Back Injury/Surgery	❑	❑
Gout	❑	❑	Knee Injury/Surgery	❑	❑
Sleeping Problems	❑	❑	Leg/Ankle/Foot Injury/Surgery	❑	❑
Psychological Problems	❑	❑	Are you pregnant?	❑	❑
Do you smoke	❑	❑			

Are you aware of what your diagnosis is? ❑ Yes ❑ No

Based on your awareness, what are your goals for Physical Therapy treatment?

_____

List any other information that you feel would assist us in your care:

_____

Please let us know how you heard about us: ❑ Physician Referral ❑ PT Associates Website ❑ Google ❑ Radio ❑ Newsletter ❑ Other, please explain: _____

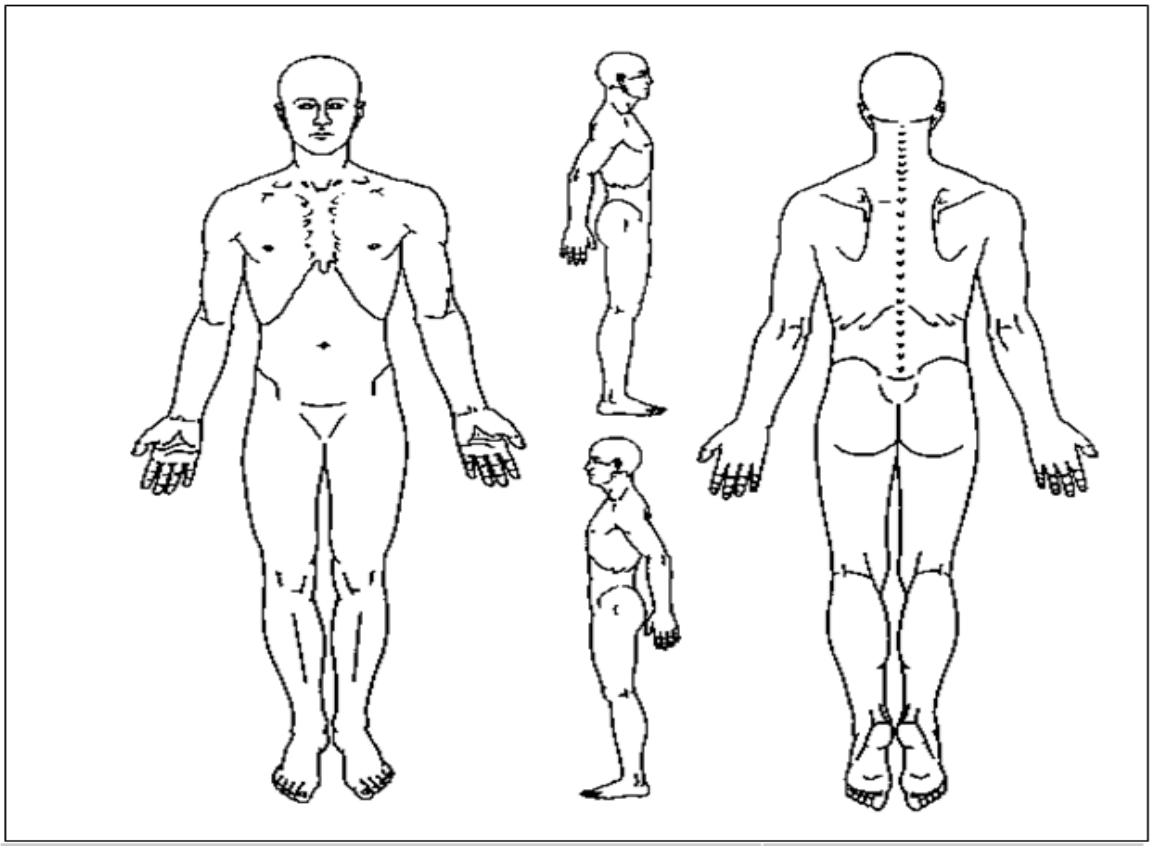
Patient/Guardian Signature: _____ Date: _____

PHYSICAL THERAPY ASSOCIATES
Sports & Orthopedic Specialists

Pain Diagram

Patient Name: _____ Date: _____

Instructions: Please indicate below the nature and location of your symptoms by using the legend.



A = ACHE	B = BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER

Instructions: Please indicate your level of pain by choosing the appropriate number on the scales below:

Current Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	None					Moderate					Severe
Pain at Least	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	None					Moderate					Severe
Pain at Worst	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	None					Moderate					Severe

PHYSICAL THERAPY ASSOCIATES

Sports & Orthopedic Specialists

MEDICAL RECORDS RELEASE

DATE: _____

TO: _____

(DOCTOR/HOSPITAL)

I HEREBY REQUEST THE RELEASE OF MY MEDICAL RECORDS OR COPIES OF SUCH AND ASK THAT THEY BE TRANSFERRED TO:

PHYSICAL THERAPY ASSOCIATES, LP
3838 50th Street
LUBBOCK, TX 79413
(806)792-5522 PHONE
(806)785-7582 FAX

_____ _____

PRINT NAME OF PATIENT SIGNATURE OF PATIENT/GUARDIAN

_____ _____

DATE OF BIRTH SOCIAL SECURITY NUMBER

PHYSICAL THERAPY ASSOCIATES, LP
3838 50th Street
Lubbock, TX 79413

NOTICE OF PRIVACY INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

Our commitment here at Physical Therapy Associates, LP is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

We understand that medical information about you and your health is personal, and we are committed to protecting this information. We create a record of the care and services you receive, and need this record to:

- plan your care and treatment;
- communicate with the many health care professionals who might be involved in your care;
- provide a means by which you or a third-party payer can verify that services billed are actually provided;
- provide you with quality care and to comply with certain legal requirements.

This notice applies to all of the records of your care at this office. It tells you about the ways we may use and disclose medical information about you, and also tells you about your rights regarding that information

By law, we are required to:

- Make every effort to insure that medical information that identifies you is kept private;
- Give you this Notice regarding your legal duties and privacy practices concerning medical information about you, and:
- Follow the provisions of the Notice that is currently in effect

This notice takes effect April 14, 2003 and will remain in effect until we change it.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU.

There are different ways that we use and disclose medical information about you. Although examples are provided where appropriate, it is impossible to list every use or disclosure in each category. However, all the ways we are permitted to use and disclose information will be in one of the categories.

- **Treatment.** We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, nurses, nursing assistants, technicians, therapy specialists, workers compensation programs, or other personnel who are involved in your health care.
- **Payment.** We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, attorney, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services we provide to you, or to determine that your health plan will pay for the treatment.
- **Health Care Operations.** We may use or disclose your health information in order to support the business activities of our practice. These may include, but are not limited to the necessary administrative, educational, quality assurance, and business functions.

USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS.

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for in the next section of this Notice.

- **Appointment Reminders.** We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.
- **Family Members and Friends.** We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures.

For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES OF HEALTH INFORMATION

- As required by law
- Emergencies

- Military activity and national security

USES AND DISCLOSURES PURSUANT TO YOUR WRITTEN AUTHORIZATION.

Except for the purposes identified in the sections noted above, we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so in writing. If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in the authorization, except to the extent that we have already taken some action in reliance upon your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding your health information.
You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from the Business Manager. In some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from the Business Manager or Privacy Officer.

- **Right to Inspect and Copy.** You have the right to inspect and copy health information that may be used to make decisions about your care.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend that information.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures of your health information made by us.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about your health care in a certain way or at a certain location.
- **Right to a Paper Copy of this Notice.** You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will maintain a copy of the current notice at the Front Desk of the clinic. You will be asked to sign a form acknowledging that you have received a copy of this Notice.

We here at Physical Therapy Associates, LP are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

Should you ever believe your privacy rights have been violated, we request you file a complaint with our Privacy Officer, Liesl Olson, PT. You may also register your complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy. Any complaint you file will be used strictly to improve our operating procedures and in doing so, you will not be retaliated against for filing a complaint.

Physical Therapy Associates, LP Acknowledgement of Receipt of Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. By signing below, I acknowledge that I have read and understand the above and understand my rights to privacy of Protected Health Information.

_____
Printed Patient Name

_____
Patient Signature/Legal Representative

_____
Date

_____
Relationship of Representative

Physical Therapy Associates, LP
3838 50th Street
Lubbock, TX 79413

Date: _____

Patient: _____
Employer: _____
Insurance Carrier: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Physical Therapy Associates, LP
3838 50th Street
Lubbock, TX 79413

- Or –

If my current policy prohibits direct payment to Physical Therapy Associates, LP I hereby also instruct and direct you to make out the check to me and mail it as follows:

Physical Therapy Associates, LP
3838 50th Street
Lubbock, TX 79413

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

Estimated Insurance Benefits _____

Estimated Patient Payment _____ Initials: _____

Arrangements for Payment of patient's share _____ Date: _____

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I also authorize and give my consent for **Physical Therapy Associates, LP** to furnish medical care and treatment considered necessary and proper in diagnosing or treating their physical and mental condition.

I authorize **Physical Therapy Associates, LP** to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20_____
(TIME) (DATE) (MONTH) (YEAR)

_____ _____
Signature of Policyholder Witness

Signature of Claimant, if other that Policyholder _____

No-Show / Cancellation Policy

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our 60-minute treatments, missed appointments are a significant inconvenience to your physical therapy, the clinic, and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $25.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

2. 24-hour notice allows us to place another patient in your cancelled appointment period to receive needed treatment. We understand there may be emergencies and there will be 2 allowable "grace" cancellations.

3. Certain accident and Worker's Compensation claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. After missing two appointments without notice (no show), you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance. We reserve the right to discharge your physical therapy and / or notify your physician if two scheduled visits are missed without notice.

Thank you for providing our office and our patients this courtesy! By signing below you indicate you understand and agree to the terms of this policy.

Signature of patient: _____ Date: _____

Signature of responsible party or guardian: _____ Date: _____

PHYSICAL THERAPY ASSOCIATES
Sports & Orthopedic Specialists

MEDICARE PATIENT QUESTIONAIRE

1.) Are you receiving home health at this time? **Yes** or **No**

2.) Have you received home health in the past year? **Yes** or **No**
If yes, have you been dismissed from all home health? **Yes** or **No**

3.) Is anyone coming to your house to bathe you? **Yes** or **No**

4.) Is anyone coming to your house to take your blood pressure? **Yes** or **No**

5.) Is anyone coming to your house to check medications or fill your medications? **Yes** or **No**

6.) Is anyone coming to your house to draw your blood? **Yes** or **No**

7.) Is anyone coming to your house for wound care? **Yes** or **No**