Patient Intake Form

Name:_____ Date: _____
Your Email Address:_____
Date of Birth:____/_____/_____ Age:_____ Social Security : _____-_____-_____
Ordering Physician/ Referring Provider: _____
Diagnosis/ Why you are here: _____

Address _____ City_____ State_____ Zip Code _____
Home # _____ Work # _____ Cell # _____

Person to Contact in Case of Emergency _____
Relationship_____ Phone Number _____

Name of Insured/ Policy Holder _____ SS#_____-_____-_____ DOB _____
Address_____ Phone #_____
Employer Name _____ Relationship to Patient_____

Primary:
Insurance Company _____
Address _____ City_____ State _____ Zip Code _____
Phone #_____ Policy/ ID # _____ Group/ Claim # _____
Claim Adjuster _____ Date of Injury_____
Secondary:
Insurance Company _____

I hereby give authorization for payment of insurance benefit to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all the charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.
I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR? YES NO

IF YES, WHICH CLINIC? _____

_____ _____
Signed Date

<u>All Schertz-Cibolo Physical Therapy</u>
Patient Medical History Form

Name: _____Occupation: _____
Date of Birth: _____Date of Injury: _____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

Have you or an immediate family member have been told you have: (please circle yes or no)

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Angina/ Chest Pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid Arthritis?	Yes	No	Yes	No

In the past 3 months have you experienced or have had: (Please circle yes or no)

A change in your health?	Yes	No
Loss of strength or energy?	Yes	No
Nausea/ Vomiting?	Yes	No
Fever/ chills/ sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel or bladder function?	Yes	No
Menstrual irregularities?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No
Often been bothered by feeling down, depressed hopeless	Yes	No
Been bothered by little interest of pleasure in doing things	Yes	No

Currently, are you: (please circle yes or no)

Pregnant?	Yes	No
Depressed?	Yes	No
Under stress?	Yes	No

Currently, I have difficulty: (circle that apply)

Driving Getting up from a chair
Walking Bending at the waist
Standing Lifting

If you are accustomed to regular exercise, check the ones that are difficult now:

Playing Sports Running Calisthenics

Do you have a history of (circle that apply)

Allergies/ Asthma Headaches
Bronchitis Kidney disease
Rheumatic fever Ulcers
Sexually transmitted disease Seizures
Testing positive for tuberculosis
Living with someone who has tuberculosis

Are your symptoms: (circle one)

Getting worse The same Improving

How are you sleeping at night? (circle one)

Fine Moderately difficult
Only with medication

Do you have any problem with? (circle all that apply)

Hearing Vision Speech Communication

How do you learn best?

Seeing Doing Hearing

Do you or have in the past smoked tobacco?

Yes No
If yes,____ packs x_____ years
Last tobacco use: _____

Do you drink alcoholic beverages? Yes No
If yes,_____/week.

Date of last physical examination: _____

Past surgical history/ list all surgeries and date: _____

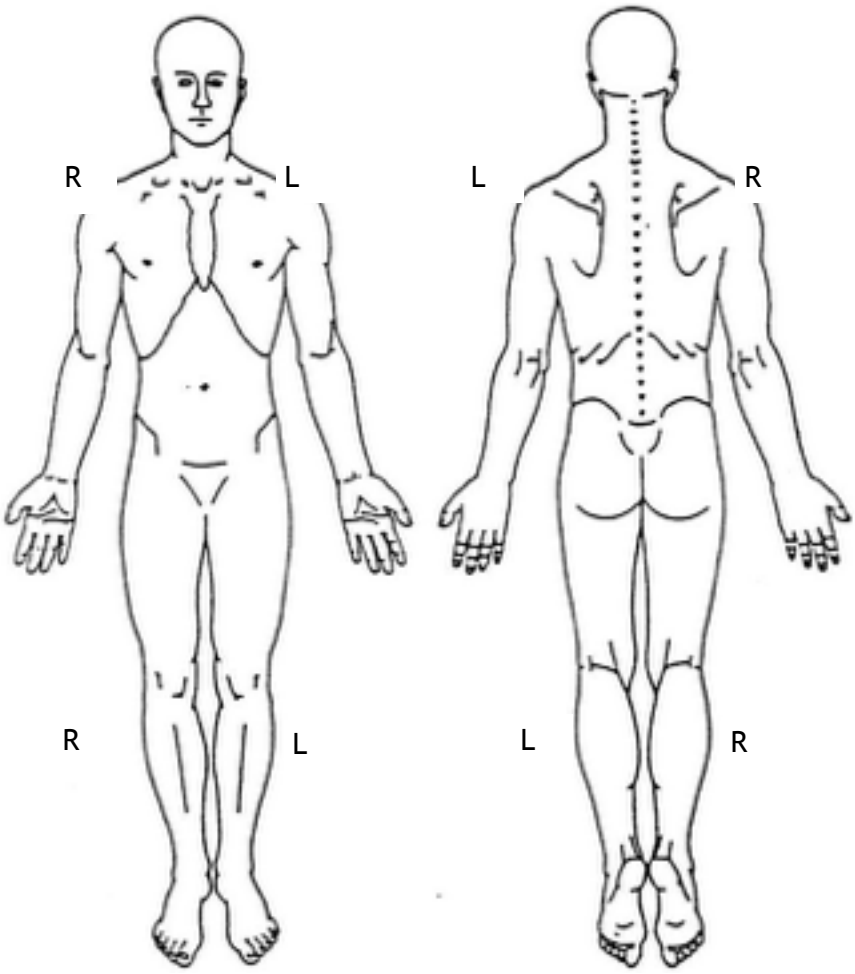
_____

List medications currently using: _____

_____

Please use the Diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

****Key: Pins and needles: 00000 Stabbing: /////**
Burning: BBBBB Ache: AAAA
Numbness: NNNNN



I believe all information to be true and complete:

Signature _____ Date _____

All Schertz-Cibolo Physical Therapy

Consent to Treat

I _____ hereby request and consent to All Schertz-Cibolo Physical Therapy to perform rehabilitative treatment and care as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment. I authorize the physical therapist to perform any additional or different treatment, which is deemed necessary should, during treatment, a condition be discovered which was not known previously.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition with the treating physical therapist.

I consent and authorize All Schertz Cibolo Physical Therapy, PLLC (including students in training) to administer treatment under the direction and supervision of the physical therapist.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Guardian (to minor) Relationship to Patient

All Schertz-Cibolo Physical Therapy

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accounting Act of 1996 (HIPAA).

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

Uses and Disclosures

Treatment. All Schertz Cibolo Physical Therapy, PLLC may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

Payment. Your health information may be used to seek payment from your health plan, for other sources of coverage such as an automobile insurer, insurance companies or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **All Schertz Cibolo Physical Therapy** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law-enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- ❑ The right to request restrictions on the use and disclosure of your protected health information
- ❑ The right to receive confidential communications concerning your medical condition and treatment
- ❑ The right to inspect and copy your protected health information
- ❑ The right amend or submit corrections to your protected health information
- ❑ The right to receive accounting of how and to whom your protected health information has been disclosed
- ❑ The right to receive a printed copy of the notice

All Schertz Cibolo Physical Therapy, PLLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting The Privacy Officer, All Schertz Cibolo Physical Therapy, 790 Roy Richard Drive, FM 3009 Suite E, Schertz, TX 78154. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
All Schertz Cibolo Physical Therapy
17323 IH 35 N, Suite #107
Schertz, TX 78154

You will not be penalized or otherwise retaliated against for filing a complaint.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Relationship to Patient:_____

Signature:_____Date:_____

I have attempted to obtain the patient's signature in Acknowledgment of this notice of Privacy Practices, but was unable to do so as documented below:

Date:_____Initials:_____Reason:_____