DEKALB•NEW BOSTON•TEXARKANA PHYSICAL THERAPY

DeKalb Location	New Boston Location	Texarkana Location	Texarkana Location
203 E. Front St	303 N. Center St	5602 Richmond Road, Ste 106	600 N Kings Hwy, Ste 2
DeKalb, TX 75559	New Boston, TX 75570	Texarkana, TX 75503	Wake Village, TX 75501
(903) 667-7000	(903) 628-7700	(903) 794-0333	(903) 794-0055
Fax (903) 667-7003	Fax (903) 628-7701	Fax (903) 794-0380	Fax (903) 794-0057

Cancellation Policy

I, _____, understand that there may be a $25.00 fee if I am unable to give a 24-hour notice of cancellation prior to scheduled appointment. The fee will not be charged to my insurance, I will be held responsible for the $25.00 Cancellation fee.

Please call one of the following numbers to cancel/reschedule:
Texarkana Office:(903) 794-0333 New Boston Office: (903) 628-0055 DeKalb Office: (903) 667-0076
If after hours, please call: (903) 667-7000

Patient Name:_____

_____ _____
Signature Date

Please note: Our overall business name is "Mount Pleasant Physical Therapy, P.C." For any services provided at any of our locations, you may see this business name listed on your medical billing and also on your banking records for any credit card payments made.

☐ Yes ☐ No I give permission for a voicemail with appointment reminders to be left at the phone numbers I list on my patient paperwork.

☐ Yes ☐ No I give permission to receive appointment reminders via text messaging to the phone numbers I list on my patient paperwork.

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Today's Date: _____ Referring Physician: _____

Patient Name: _____ Sex: M or F

Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____

Occupation: _____ Employer: _____

Marital Status: _____ Name of Spouse: _____ Date of Birth: _____

(If under age 18), Name of Guardian: _____ Date of Birth: _____

Who may we call in case of emergency?: _____ Phone: _____

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES?

Yes _____ No _____ If YES, which agency? _____

BILLING INFORMATION

Please provide TEXARKANA / DEKALB / NEW BOSTON PHYSICAL THERAPY with your insurance cards so that we may make a copy. If you do not have them with you, please fill in the information below.

Name of person responsible for bill: _____

DOB: _____ Sex: M or F

Address: _____
City State Zip

Primary Insurance Carrier: _____

Employer Name: _____ Phone Number: _____

Address: _____
City State Zip

Insurance ID #: _____ Group #: _____

Signature: _____ Date: _____

PAST MEDICAL HISTORY

Name: _____ Date: _____

Social / Health Habits:

A. Do you use tobacco products? YES _____ NO _____

1. If so, how often? _____
2. How much? _____
3. How long have you used tobacco products? _____

B. Are you pregnant or think you could be? YES _____ NO _____

C. Do you have a Pacemaker? YES _____ NO _____

Medical / Surgical History: *Please check if you have ever had or currently have any of the following:*

_____ Arthritis
_____ Broken Bones / Fractures
_____ Osteoporosis
_____ Blood Disorders
_____ Stroke
_____ Diabetes / High Blood Sugar
_____ Hypoglycemia / Low Blood Sugar
_____ Head Injury
_____ Multiple Sclerosis
_____ Muscular Dystrophy
_____ Parkinson Disease
_____ Seizures / Epilepsy
_____ Allergy
_____ Developmental or Growth Problems

_____ Circulation / Vascular Problems
_____ Heart Problems
_____ High Blood Pressure
_____ Lung Problems
_____ Cancer
_____ Infectious Disease
_____ Kidney Problems
_____ Repeated Infection
_____ Ulcers / Stomach
_____ Skin Disease
_____ Depression
_____ Thyroid Problems

Other:

_____

Please list all surgeries and dates that you have had: _____

_____

_____

_____

Please list current medications: _____

_____

_____

_____

Thank you for taking the time to complete these forms. Our therapists want to get as much background information on your condition as possible to enable them to give you the best treatment. Once you have completed these forms, please return to the front desk and a therapist will be with you as soon as possible.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used at *Texarkana / DEKALB / NEW BOSTON PHYSICAL THERAPY* and your rights concerning those records. Before we begin any health care services, we must require you to read and sign this Consent Form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this Consent.

1. The Patient understands and agrees to allow this physical therapy office to use their PHI for the purpose of treatment, payment, healthcare services and coordination of care. As an example, the Patient agrees to allow *TEXARKANA / DEKALB / NEW BOSTON PHYSICAL THERAPY* to submit requested PHI to the Health Insurance Company(ies) provided to us by this Patient for the purpose of payment. Be assured that *TEXARKANA / DEKALB / NEW BOSTON PHYSICAL THERAPY* will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The Patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The Patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. *TEXARKANA / DEKALB / NEW BOSTON PHYSICAL THERAPY* is not obligated to agree to those restrictions.
3. A Patient's written Consent need only be obtained one time for all subsequent care given the Patient at *TEXARKANA / DEKALB / NEW BOSTON PHYSICAL THERAPY.*
4. The Patient may provide a written request to revoke consent at any time during care. This would NOT affect the use of those records for the care given prior to the written request to revoke Consent; but would apply to any care given after the request has been submitted.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy. A Privacy Official has been designated to enforce those procedures at *TEXARKANA / DEKALB / NEW BOSTON PHYSICAL THERAPY*. We have taken all precautions to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a Formal Complaint with our Privacy Official about any possible violations of these policies and procedures.
7. If the Patient refuses to sign this Consent Form for the purpose of treatment, payment and/or health-care services, the therapist has the right to refuse care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

X_____ _____

Name of Patient Date

Patient's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long term authorization.

X_____ _____

Signature Date

Insured or Authorized Person's Signature

I authorize payment of medical benefits for the services on the insurance form. This authroziation is to apply to all occassions of service until it is revoked in writing. I agree to pay for the services not covered by insurance and understand that I am ultimately responsible for payment in full to *TEXARKANA / DEKALB / NEW BOSTON PHYSICAL THERAPY.*

X_____ _____

Signature Date

ACKNOWLEDGMENT OF PATIENT RIGHTS

I, _____, acting on behalf of
(Print Name of Patient of Legal Authorized Representative)
_____, hereby consent to the administration of such tests and treatment that, in judgement of the therapist is deemed necessary or advisable.

I understand that should any specific treatment or tests, which in the judgement of the therapist pose a specific risk, be required, the Patient or Legal Authorized Representative will be asked to sign a separate Consent Form specifying the procedure or test.

It is understood that patients have certain rights and responsibilities. Patients have the right to consent to or refuse medical treatment. They have the right to be reasonably informed as to the course of events occurring during their treatments and have a right to participate in decisions involving their care. Patients have the right to obtain a copy of their medical records from *TEXARKANA / DEKALB / NEW BOSTON PHYSICAL THERAPY* to examine the records during regular business hours **(Monday - Friday from 8:00 am to 12:00 pm and 1:00 pm to 5:00 pm)**.

_____	_____
Signature of Patient	Date
_____	_____
(Signature of Legally Authorized Representative if Patient unable to sign)	Date
_____	_____
Witness	Date

Consent read to Patient by: _____

Patient Name: _____ Date: _____

History of Current Injury

Date of onset of current injury / symptoms: _____
Brief description of current injury / symptoms: _____
_____

Is injury work related? YES _____ NO _____ If yes, is injury beig filed as Workman's Compensation? YES _____ NO _____ Has Supervisor been notified? YES _____ NO _____

Is injury a result of a car accident? YES _____ NO _____ If yes, is there a lawyer or litigation involved? YES _____ NO _____

Have you had surgery as a result of your current injury / symptoms? YES _____ NO _____
Surgery Date: _____ Procedure performed: _____

Have you ever had a similar injury / symptoms in the same area prior to current episode?
YES _____ NO _____ If yes, when? _____

Have you had prior physical therapy for this injury / symptoms? YES _____ NO _____
If yes, duration of treatment: _____

Have you had an MRI, X-RAY, or CT Scan for current injury / symptoms? YES _____ NO _____
Findings: _____

Patient Name: _____ Date: _____

What activities make your pain worse? (Check all that apply)

_____ Prolonged Sitting	_____ Prolonged Standing	_____ Squatting
_____ Walking	_____ Running	_____ Jumping
_____ Up / Down Stairs	_____ Forward Bending	_____ Lying Down
_____ Reaching Overhead	_____ Lifting Objects	_____ Transitional Skills

_____ Other _____

What improves your pain?_____

_____

Pain Scale

1= No Pain - 10= worse pain imaginable (emergency room severeness)

0 1 2 3 4 5 6 7 8 9 10

1. Please rate your pain currently: (0-10) _____
2. Please rate your pain at the best in the past week: (0-10) _____
3. Please rate your pain at the worst in the past week: (0-10) _____

Please indicate areas of pain with **(//////)** markings below on body pictures.

Please indicate areas of numbness / tingling with **(xxxxx)** markings below on pictures.

Please **circle** any areas of swelling on the pictures.