



# DEKALB • NEW BOSTON • TEXARKANA • HOPE PHYSICAL THERAPY & SPORTS MEDICINE

DeKalb Location 203 E. Front St DeKalb, TX 75559 (903) 667-7000 Fax (903) 667-7003	New Boston Location 303 N. Center St New Boston, TX 75570 (903) 628-7700 Fax (903) 628-7701	Texarkana Location 5416 Plaza Dr. Texarkana, TX 75503 (903) 794-0333 Fax (903) 794-0380	Texarkana Location 600 N Kings Hwy, Ste 2 Wake Village, TX 75501 (903) 794-0055 Fax (903) 794-0057	Hope Location 2510 N. Hervey St. Hope, AR 71801 (870) 474-5060 Fax (870) 474-5061
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## Cancellation Policy

I, \_\_\_\_\_, understand that there may be a \$35.00 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 \$35.00 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:*

- |   |  |
|---|--|
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Circulation / Vascular Problems |
| <input type="checkbox"/> Broken Bones / Fractures         | <input type="checkbox"/> Heart Problems                  |
| <input type="checkbox"/> Osteoporosis                     | <input type="checkbox"/> High Blood Pressure             |
| <input type="checkbox"/> Blood Disorders                  | <input type="checkbox"/> Lung Problems                   |
| <input type="checkbox"/> Stroke                           | <input type="checkbox"/> Cancer                          |
| <input type="checkbox"/> Diabetes / High Blood Sugar      | <input type="checkbox"/> Infectious Disease              |
| <input type="checkbox"/> Hypoglycemia / Low Blood Sugar   | <input type="checkbox"/> Kidney Problems                 |
| <input type="checkbox"/> Head Injury                      | <input type="checkbox"/> Repeated Infection              |
| <input type="checkbox"/> Multiple Sclerosis               | <input type="checkbox"/> Ulcers / Stomach                |
| <input type="checkbox"/> Muscular Dystrophy               | <input type="checkbox"/> Skin Disease                    |
| <input type="checkbox"/> Parkinson Disease                | <input type="checkbox"/> Depression                      |
| <input type="checkbox"/> Seizures / Epilepsy              | <input type="checkbox"/> Thyroid Problems                |
| <input type="checkbox"/> Allergy                          |  |
| <input type="checkbox"/> Developmental or Growth 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 authorization is to apply to all occasions 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 or 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 being 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.

