Patient Intake Form

Name ______________________SS# _____-_____-_______ Date of Birth ___________

Address _________________________ City________________ State____ Zip _______

Home # ____________________________ Work # ______________________________

Cell # ______________________Email Address:________________________________

Would you like to receive appointment reminders? __ Email __ Text __ Voice

Person to Contact in Case of Emergency ____

Relationship_____________________ Phone Number ___________________________

Referring Physician ____________________________________

Primary

Insurance Company ____

Policy/ ID # ____________________ Group/ Claim # ________________

Name of Insured/ Policy Holder _____________________ SS#______-_____-______

DOB ______________ Address____

Phone #________________________Relationship to Patient_____________________

Secondary

Insurance Company ____

Policy/ ID # ____________________ Group/ Claim #_____________

Are you currently receiving Home Health? Yes No

Have you received Physical Therapy this year? Yes No

I hereby give authorization for payment of insurance benefit to be made directly to Schertz Parkway Physical Therapy, PLLC for services rendered. I understand that I am financially responsible for all the charges not paid by my insurance company. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. 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).

____ ___________

Signed **Date**

Patient Medical History Form

Name:_______________________________________ DOB:______________________

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.

Patient Medical History: (please circle any condition for which you have received treatment. Items not circled understood to be negative.)

High Blood Pressure	Asthma	Recent Weight Loss/ Gain
Heart Problem	Emphysema	Thyroid Problem (Hyper or Hypo)
Abnormal Heart Rate	Chronic Lung Problem	Diabetes (medical dependent? ______________)
Pacemaker	Chronic Heartburn	Cancer (where?____________)
Heart Palpitations	History of Ulcers	Epilepsy/ Seizure
Angina (chest pain)	High Cholesterol	
Heart Murmur	Bowel or Bladder Problems	
Abnormal Bleeding	AIDS/ HIV Positive	

Other:____

Do you have a history of fractures? YES NO Where? ______________________________

Do you have a history of back/ neck pain? YES NO When?______________________________

Do you have any metal implants? YES NO Where?______________________________

Do you smoke? YES NO How much per day? ________________________

Do you exercise regularly? YES NO How often?____________________________

Do you have known drug allergies? YES NO Please list____________________________

Are you pregnant or suspect pregnancy? YES NO

In regards to your current condition: please rate your pain none [0-1-2-3-4-5-6-7-8-9-10] worst

Do you have any "pins and needles" or numbness in your extremities? YES NO

Do you have any weakness in your arms or legs? YES NO

Do you have any coordination or balance problems? YES NO

Do you have difficulty walking? YES NO

Do you experience dizziness of vertigo with a change in position? YES NO

Have you experienced headaches as a result of your condition? YES NO

Were you injured in a work related incident? YES NO

Please list all current medications : ____

____

Please list all surgeries/ dates: ____

____

Please check diagnostic tests performed: [ ] X-ray [ ] MRI [ ] CT Scan [ ] Bone scan [ ] Bone Density [ ] EMG [ ] Ultrasound

Please describe your chief complaint and current condition: ________________________________

____

I believe all information to be true and complete: **Signature** ___________________________ **Date** __________

Consent to Treat

I ________________________________ hereby request and consent to Schertz Parkway 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 Schertz Parkway 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

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.

Schertz Parkway 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).

Uses and Disclosures
Treatment: Schertz Parkway 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 **Schertz Parkway 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

Schertz Parkway 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, Schertz Parkway Physical Therapy, 392 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
Schertz Parkway Physical Therapy, PLLC
392 Schertz Parkway
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:____

**** To protect our patients' privacy, we will not release information about appointment times to anyone other than the patient, unless the patient gives us express permission. Please list anyone you permit to inquire about appointment times, scheduling, and cancellation below:**

NAME	RELATION TO PATIENT

Schertz Parkway Physical Therapy

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