Get Physical Rx
BALANCE & PHYSICAL THERAPY CENTERS

PATIENT HISTORY

Patient's Name _____ Date of Birth _____
(last) (first) (middle)

Mailing Address _____
(number and street) (city) (state) (zip)

Home # (___) _____ Cellular # (___) _____ Work # (___) _____

Social Security # _____ Employer _____

Email address _____

In Case of Emergency Contact _____ Phone # (___) _____

Referring Physician _____ Date of Injury _____

Primary Care Physician _____

► INSURANCE – do not fill out if presenting card◄

Primary Insurance Name and Address _____

Subscriber's Name _____ Group # _____ ID # _____

Secondary Insurance Name and Address _____

Subscriber's Name _____ Group # _____ ID # _____

► Workers Compensation Carrier ◄ _____ Claim # _____

► IF PATIENT IS UNDER THE AGE OF 18 ◄

Mother's Name _____ Employer _____

Work # (___) _____ Social Security # _____

Father's Name _____ Employer _____

Work # (___) _____ Social Security # _____

For patients under 18 years of age, the parent, relative, or person *escorting* the patient is responsible for any payments due at the time of the service.

- I understand that I am responsible for all charges incurred regardless of insurance or third party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize Get Physical Rx Balance and Physical Therapy Centers to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to Get Physical Rx Balance and Physical Therapy Centers.

Signature **Date**

2940 FM 2920 Rd Ste 170 • Spring, Texas 77388
Phone: 346-386-6683 • Fax: 346-386-0986

Get Physical Rx Balance and Physical Therapy Centers Financial Agreement

This is an agreement between Get Physical Rx and
_____.
(please print name)

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Get Physical Rx Balance and Physical Therapy Centers
By executing this agreement, you are agreeing to pay for all services that are received.

Please select the option(s) you prefer:
_____I will make payments at time of service
_____I will make a payment arrangement for my account
_____**Work Related** My workers compensation carrier authorized physical therapy
_____**Motor Vehicle** A motor vehicle insurance company authorized physical therapy

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/rebilling charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have NO insurance:

You choose to pay by _____cash, ____check, or _____credit card at the time the services are rendered. Our cash payment option for patients without insurance is $100 per visit. Payment is expected at time of service. If extenuating circumstances should arise, you can discuss a payment plan with our Practice Manager, Becky Couch.

Payment options if you have insurance:

1. If you still have a deductible to meet, you choose to pay $100 by ____cash, ____check, or ____credit card at the time services are rendered. We will send your claim to your insurance carrier and will bill you for any additional patient responsibility, if any, which is determined by your carrier.

2. You choose to pay your co-payment, determined by your insurance carrier, by ____cash, ____check, or ____credit card at the time services are rendered. If there is a balance on your account at the end of the month we will bill you accordingly. Any balances without a payment within 30 days of the date of service will be charged a recurring $6 monthly rebilling/finance charge until services are paid in full.

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Payments: Unless other arrangements are approved by either Dr. Benjamin Cilento, Owner, or Becky Couch, Practice Manager, the balance of your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your coverage eligibility. **If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company, and/or a higher patient financial responsibility.**

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your coverage eligibility. You agree to pay any portion of the charges not covered by insurance.

Appointment of Representative: I, the undersigned, represent that I have a valid and in-force insurances and/or employee health care benefits coverage, and hereby assign and convey directly to, **GET PHYSICAL RX PHYSICAL THERAPY and BALANCE CENTERS and all medical professionals, including all physical therapists associated with GET PHYSICAL RX PHYSICAL THERAPY and BALANCE CENTERS,** as my Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurances or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPPA.

The provider has the permission to submit disputes on my behalf for any claims related to my care from a Get Physical Rx Provider.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We reserve the right to refer your account to an attorney or collection agency. You agree to pay all attorney fees and collection costs incurred in enforcing the terms of this agreement.

Returned Checks: There is a $25 fee for any checks returned by your bank.

Missed Appointments: 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.

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Workers Compensation: We require written approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

Motor Vehicle Accidents: If the insurance policy involved in any motor vehicle accident claim does not accept liability for your claim, you will be held responsible for your payments in full.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible Party: _____
(if not the patient)

Signature: _____

Date: _____

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RELEASE OF INFORMATION

Get Physical Rx Balance and Physical Therapy Centers
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Thank you for referring your patient to Get Physical Rx Balance and Physical Therapy Centers.

Please forward the medical records regarding this patient so we may provide proper treatment to your patient.

I authorize the release of and correspondence regarding my (or my dependent's) medical records to Get Physical Rx Balance and Physical Therapy Centers.

Date _____

Patient Name _____

Date of Birth _____

_____ _____

Signature **Date**

Informed Consent for Physical Therapy

Get Physical Rx
Balance and Physical Therapy Centers

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Get Physical Rx Balance and Physical Therapy Centers does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. In the event of a change in medical status, I understand that my treatment may be modified, stopped, or referred out to the proper practitioner. I reserve the right to withdraw at any time.

I agree to hold Get Physical Rx Balance and Physical Therapy Centers harmless for claims or damages in connection with treatment. This is a contract between myself and Get Physical Rx Balance and Physical Therapy Centers, and I understand that it is also a release of potential liability.

BY CHECKING YES BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____Yes, I agree

Patient's Name: _____Patient's Signature: _____Date: _____

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BALANCE & PHYSICAL THERAPY CENTERS

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosure of Health Information:
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:
Except as stated in more detail in the Notice of Privacy Practice, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____
Patient Name (please print)

_____
Parent or Authorized Representative (if applicable)

_____ _____
Signature **Date**

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PATIENT HISTORY FORM

*Note: This is a confidential record and will be kept in your PT chart. Information contained here will not be released to anyone without your authorization to do so.

Last Name _____ First Name _____ Middle _____

Today's Date ____ /____ /____ Date of Birth ____ /____ /____

Date of last Physician exam ____ /____ /____

BMI: Height _____ Weight _____

History of Present Problem

Please answer the following questions

What is the main reason for your Physical Therapy evaluation today?

_____

_____

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), circle the number that best describes your average pain?

0 1 2 3 4 5 6 7 8 9 10

Problem **worsens** with:
Movement Inactivity Standing Lying Sitting
Other _____
_____

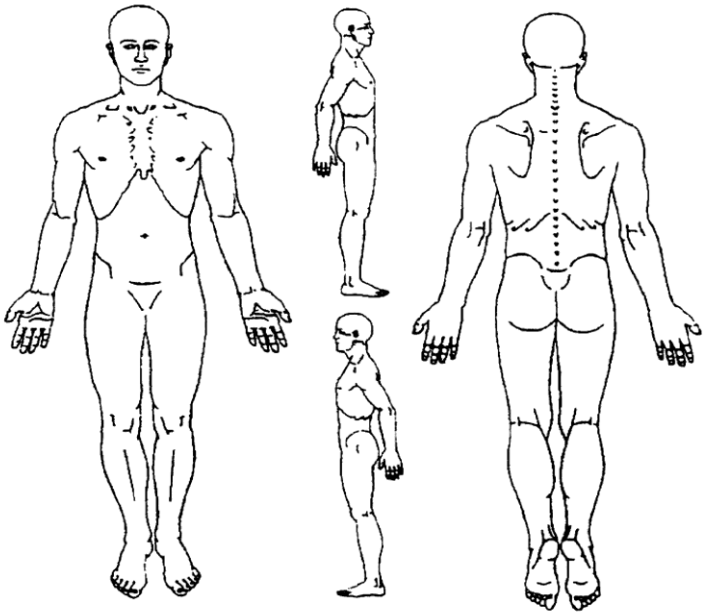
Problem **improves** with:
Movement Inactivity Standing Lying Sitting
Rest Medication Heat Ice
Other _____

How frequently are you bothered by this problem?
Constant Occasional/Variable
Other _____

How would you describe the problem?
Dull Sharp Dull then Sharp Very sharp then leaves
Other _____

Do you have any other symptoms?
Yes No If yes, please explain _____

Please mark the location of the pain



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PAIN LOCATIONS OTHER THAN REFERRAL REASON

Do you experience pain in any other areas of your body on a regular basis? Yes / No

Have you seen a Pain Management doctor for your past or current pain symptoms? Yes / No

If yes, who is your Pain Management doctor? _____

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), circle the number that best describes your average pain?

0 1 2 3 4 5 6 7 8 9 10

Problem **worsens** with:
Movement Inactivity Standing Lying Sitting
Other _____
_____

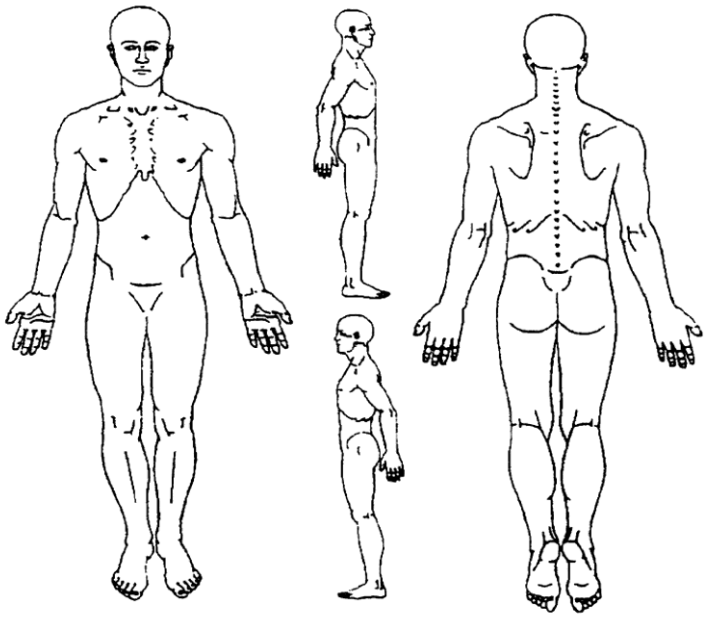
Problem **improves** with:
Movement Inactivity Standing Lying Sitting
Rest Medication Heat Ice
Other _____

How frequently are you bothered by this problem?
Constant Occasional/Variable
Other _____

How would you describe the problem?
Dull Sharp Dull then Sharp Very sharp then leaves
Other _____

Do you have any other symptoms?
Yes No If yes, please explain _____

Please mark the location of the pain



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Past Medical & Social History

List any personal past illnesses &/or surgeries and when they occurred.

Illness or Surgery	Date
_____	_____
_____	_____
_____	_____

List all serious illnesses in your family. (Example: Diabetes, Tuberculosis, Breast Cancer, Heart disease, etc.)

_____
_____
_____

Are you on any prescription medications? Yes No (If Yes, List all)

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any over the counter medications? No Yes Please explain _____
Do you have allergies? No Yes Please explain _____

Do you smoke? No Yes How much?_____
Do you drink? No Yes How much?_____
How much caffeine do you consume daily? _____

Review of System

Y N

Do you now or have you had any problems related to the following systems? Circle or Please explain any yes answer.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Muscle Pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other _____		

Genitourinary

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Numbness/tingling Y N
Other _____

Endocrine
Excessive thirst Y N
Too hot/cold Y N
Tired/Sluggish Y N
Diabetes Y N
Other _____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

Cardiovascular
Chest pain Y N
Stroke Y N
Varicose veins Y N
High blood pressure Y N
Other _____

Urine Retention Y N
Painful Urination Y N
Urinate Frequently Y N
Incontinence/Leaking Y N
Other _____

Respiratory
Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Pneumonia Y N
Other _____

Hematologic/Lymphatic
Swollen glands Y N
Blood clotting problem Y N
Other _____

Psychologic
Are you generally satisfied with your life? Y N
Have you considered suicide? Y N
Other _____

1) Do you have any other conditions that may limit your response to exercise?
Y___ N ___ If yes, Please explain: _____

2) What are your hobbies/recreational activities? _____

3) Have you had any recent illnesses within the past 2-3 weeks? (i.e. Colds, flu, bladder/kidney infection.)
Y___ N ___ If yes, Please explain: _____

4) Have you noticed any lumps or thickening of skin or muscle anywhere in your body?
Y___ N ___ If yes, Please explain: _____

5) Do you have any sores which haven't healed or any changes in size, shape or color of wart or mole?
Y___ N ___ If yes, Please explain: _____

6) Do you have any special needs and or considerations?
Y___ N ___ If yes, Please explain: _____

7) Have you had any unexplained weight loss or gain in the last month?
Y___ N ___ If yes, Please explain: _____

8) Is there a possibility that you may be pregnant? Y___ N ___

9) How did you hear about Get Physical Rx? Please check all that apply.

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Doctor recommendation	_____	Location	_____
Friend recommendation	_____	Prior patient	_____
Saw sign	_____	Newspaper Ad	_____
Internet search	_____	Phone Book	_____
Website	_____	Other Please explain:	_____

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