



Date: \_\_\_\_\_

### Initial visit Medical History

Name (First Last): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Marital Status: S, M, D, W**

**Insurance:** \_\_\_\_\_

**Policy Holder Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Policy Holder Social Security Number** \_\_\_\_\_

**Privacy Notice:**

All North Texas Physical Therapy employees, volunteers, and students will comply with this Notice. We realize that your medical information is important to you and for that reason we protect the privacy of Protected Health Information ("PHI"). PHI is medical or payment information that identifies you. As part of our efforts to protect your PHI, we are providing you with this Joint Notice of Privacy Practice ("Notice"). This Notice explains how, when, why we will use and disclose your PHI. This Notice explains the rights and obligations you have regarding the use and disclosure of your medical information. We are required by law to follow the privacy practice regulations and the provision described in this Notice.

I acknowledge that I have received information regarding the Policies of North Texas Physical Therapy regarding **Why We Collect and How We Use Information, How We Protect Information, Information Disclosure, Rights you have regarding your PHI, This Privacy Notice is HIPPA (Health Insurance Portability and Accountability Act) Compliant.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**HISTORY:**

What activities are you having trouble with?

What are your goals for physical therapy?

When did your symptoms start?

What caused your current problem?

What has changed in the last 90 days that has made you come to therapy?

Primary Care Doctor?

Referring Doctor?

What activities do you have difficulty with because of your current problem?

Dressing  Sleeping  Self Care  Household tasks  Hobbies/Sports  
 Driving  Lifting  Carrying  Work tasks  Bending  Other

Are your symptoms getting:  Better  Worse  No Change

Describe your pain:

Intermittent  Constant  Sharp  Dull  Aching  Shooting

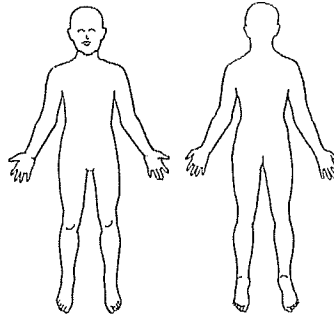
Are you currently working?  Yes  No If no, last day worked

Are your duties limited by your symptoms?  Yes  No

Occupation:

Draw the areas of pain including any areas of numbness, tingling, and/or radiation:

Right Left / Left Right



What makes the symptoms better?

What makes the symptoms worse?

Is your pain worse at night?

Circle on the graph **TODAY's Pain level:** (0=no pain, 10=Worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Circle the worse pain ever?

0 1 2 3 4 5 6 7 8 9 10

Circle the pain at its best?

0 1 2 3 4 5 6 7 8 9 10

Treatment received from this problem:  PT  MD/DO  Chiropractor  Other

Tests performed:  X-Ray  MRI  CT Scan  EMG  Nerve Blocks

Please list any current medications:

Allergies:

If female, are you pregnant?  Yes  No

What additional activities that you are having trouble with that you would like to change with physical therapy?

Do you have any history or currently have problems with the following:

Dizziness  Arthritis/Joint Pain  Cancer  Heart/circulation  
 Asthma  Diabetes  Incontinence  Balance Deficits  Diabete  
 Seizures  High Blood Pressure  Headaches  Psychological  
 Surgeries  Other:

**Medicare Patients Only**

If you are a Medicare recipient, have you received any outpatient services in 2009? \_\_\_\_\_

If Yes, how many visits of physical or speech therapy did you receive and for what condition? \_\_\_\_\_

Are you receiving home health services? \_\_\_\_\_

If so, what is the name of the company? \_\_\_\_\_

Does anyone come into the home to clean or help you cook? \_\_\_\_\_

Have you recently been discharged from the hospital? \_\_\_\_\_ Which hospital? \_\_\_\_\_

Please circle the following that apply to you:

<b>Cardiovascular System</b>	Yes	No	<b>GI System</b>	Yes	No
Elevated cholesterol	Yes	No			
Bi-Pass	Yes	No	Difficulty swallowing	Yes	No
Sweating associated with pain	Yes	No	Heartburn	Yes	No
Palpitations	Yes	No	Jaundice	Yes	No
Swelling of extremities	Yes	No	Specific food intolerance	Yes	No
History of Smoking	Yes	No	Constipation	Yes	No
Orthopnea (difficulty breathing)	Yes	No	Diarrhea	Yes	No
<b>G.U. System</b>	Yes	No	Rectal Bleeding	Yes	No
Dysuria (painful urination)	Yes	No	Gall bladder problems	Yes	No
Hematuria (blood in urine)	Yes	No	Liver problems	Yes	No
Incontinence	Yes	No	<b>Pulmonary System</b>	Yes	No
Frequency if urination	Yes	No	Dyspnea (labored breathing)	Yes	No
Urinary urgency	Yes	No	Wheezing	Yes	No
Vaginal discharge	Yes	No	Prolonged cough	Yes	No
Dysmenorrhea (painful Menstruation)	Yes	No	Sputum production	Yes	No
Post Menopausal vaginal bleeding	Yes	No	amount & color	Yes	No
Infertility	Yes	No	<b>Endocrine System</b>	Yes	No
Hx of STD	Yes	No	Excessive thirst	Yes	No
Date of last Period	Yes	No	Excessive hunger	Yes	No
Painful Intercourse	Yes	No	Polyuria (large volume of urine)	Yes	No
<b>Neurological System</b>	Yes	No	Excessive sweating	Yes	No
Ataxia (poor muscular coordination)	Yes	No	Fatigue	Yes	No
Memory lapses	Yes	No	Weakness	Yes	No
Confusion	Yes	No	Thyroid problems	Yes	No
Head Trauma	Yes	No	<b>Other Systems</b>	Yes	No
Neurological disorder	Yes	No	ENT (ears, nose, throat)	Yes	No
Tremors	Yes	No	Integumentary (skin)	Yes	No
Slurred speech patterns	Yes	No	Lymphatic	Yes	No
Hearing/Visual disturbances	Yes	No	Psychiatric	Yes	No
			Musculoskeletal	Yes	No

Are there any reasons that may limit your ability to participate with therapy? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent or Patient legal guardian

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date

## PRIVACY NOTICE TO OUR CUSTOMERS

*North Texas Physical Therapy strongly believes in protecting the confidentiality and security of information we collect about you. This notice describes our privacy policy and describes how we handle the information we receive about you.*

### **Who will follow this notice?**

All North Texas Physical Therapy employees, volunteers, and students will comply with this Notice. We realize that your medical information is important to you and for that reason we protect the privacy of Protected Health Information ("PHI"). PHI is medical or payment information that identifies you. As part of our efforts to protect your PHI, we are providing you with this Joint Notice of Privacy Practice ("Notice"). This Notice explains how, when, why we will use and disclose your PHI. This Notice explains the rights and obligations you have regarding the use and disclosure of your medical information. We are required by law to follow the privacy practice regulations and the provision described in this Notice.

**Why We Collect and How We Use Information:** We collect information for business purposes with respect to our health care provider relationship with you. These business purposes include administering our products and services and processing the transactions related to this service. We may use and disclose your PHI:

- **For Treatment:** We may disclose PHI about you to physicians, nurses, therapists, and others who are directly involved in your care. For example: a video may be taken of therapy to evaluate your progress.
- **To Obtain payment for treatment:** We may use PHI about you in order to bill and collect payment to treatment and services rendered. For example: our billing department may send medical information to your insurance company so that the claim can be processed.
- **For healthcare operations:** We may use and disclose your PHI to perform the functions of the facility. For example: We may use information about you and other patients to evaluate how well our facility provides services to the patients.

**How We Collect Information:** We get most information directly from you. The information that you give us when registering for our products and services generally provides the information we need. If we need to verify information or need additional information we may obtain information from third parties such as insurers, physicians, hospitals and other medical personnel. Information collected may relate to your finances, employment, health, avocations, or other personal characteristics as well as transactions with us.

### **How We Protect Information:**

We treat information in a confidential manner. Our employees are required to protect the confidentiality of information. Employees may access information only when there is an appropriate reason to do so, such as to administer or offer our services. We also maintain physical, electronic, and procedural safeguards to protect information. These safeguards comply with all applicable laws established by the Health Insurance Portability and Accountability Act.

**Information Disclosure:** We may disclose information when we believe it is necessary for the conduct of our business, or where law requires disclosure. For Example, information may be disclosed to others to enable them to provide a business service with us, such as helping us to evaluate requests for insurance benefits, to perform general administrative activities or to otherwise assist us in servicing or processing a health care product or service. Information may also be disclosed for audit purposes, or to law enforcement and regulatory agency for example to help prevent fraud. Information may be disclosed to others such as companies that process data for us, company's that provide general administrative services for us, and other healthcare providers. We may make other disclosures of information as permitted by law.

We may also provide information: (i) to others to assist us in offering our products and services to you, and (ii) to companies with which we have joint marketing agreement. We do make any other disclosures of information to other companies who may want to sell their products or services to you. For example, we do not sell your name to a catalog company.

### **Rights you have regarding your PHI:**

The right to request restrictions on uses and disclosures of your PHI.

The right to choose how we send PHI to you. You have the right to request that we send information regarding your health treatment, services and PHI to an alternate address. We will honor your request if we can easily provide the information in the format requested.

The right to inspect your PHI. You have the right to inspect and copy your medical and billing records. Send your request in writing to our facility. We are allowed to charge you a fee for the cost of copying, mailing, and other costs associated with your request.

The right Access to and Correction of Information: Generally, upon written request, we will make information available to you for your review that we are not prohibited from disclosing. If you notify us that the information is incorrect, we will review it. If we agree, we will correct our records. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure information.

The right to accounting of disclosures: You have the right to request an accounting of disclosures that we made about you for non-treatment, non-payment, non-operating purposes.

**Further Information:** For any additional information regarding our privacy policy, please contact North Texas Physical Therapy, LLC at 5950 Bryant Irvin Rd. Suite 200, Fort Worth, Texas 76132.

**This Privacy Notice is HIPAA (Health Insurance Portability and Accountability Act) Compliant.**

**NORTH TEXAS PHYSICAL THERAPY, PLLC**  
**Patient Consent Form**

**CONSENT TO TREATMENT.** Knowing that I have a condition requiring health care, I voluntarily consent to such health care, including diagnostic procedures and medical treatment ordered by my physicians. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the treatments or examinations. I understand that persons in professional training programs may be among the individuals who provide care to me. I understand that in connection with my treatment, photos or videos may be taken.

**NOTE TO PATIENTS.** I understand that the referring physicians, residents, interns, physician assistants, nurse care practitioners who provide me with medical treatment are not employees or agents of North Texas Physical Therapy but rather are independent and solely responsible for their own medical decisions.

**JOINT NOTICE OF PRIVACY PRACTICE & PATIENT BILL OF RIGHTS.** I acknowledge that I received a copy of the Joint Notice of Privacy Practice and that I have had the opportunity to review it and ask questions. If I refuse to accept the receipt of Joint Notice, I acknowledge that a good faith effort was made to present me with the document and my reason for refusing to accept this section and receipt of the Joint Notice is

**ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER.** I understand that, if a health care worker is accidentally exposed to my blood or other body fluids, I will be tested for Hepatitis B, Hepatitis C, or HIV without my specific consent. Test results will be kept confidential to the extent allowed by law.

**TOBACCO-FREE ENVIRONMENT.** I am aware that all of North Texas Physical Therapy areas are tobacco-free environments and that the use of any tobacco product is strictly prohibited.

**PROHIBITION OF DRUGS, ALCOHOL, AND WEAPONS.** I understand that North Texas Physical Therapy policy prohibits the consumption, use, or possession of non-prescribed drugs (including controlled substances), alcohol, or weapons on any of North Texas Physical Therapy property. If such substances are found I may be discharged immediately and local police will be notified.

**PERSONAL ITEMS.** I have been advised to leave my personal items at home and understand that North Texas Physical Therapy will not be responsible for any personal items lost, stolen, or damaged.

**AUTHORIZATION FOR MEDICAL INFORMATION RELEASE.** I authorize North Texas Physical Therapy to furnish my insurance company with medical information they may request regarding my condition or treatment. Furthermore, I authorize my referring medical provider to release any diagnostic reports or surgery reports to North Texas Physical Therapy.

**CANCELLATION POLICY.** I understand that a \$25.00 fee will be assessed for failure to supply North Texas Physical Therapy with a 24-hour notice of cancellation of my appointment. The fee will be added to my account and will be payable at my next scheduled visit. This fee is not reimbursed by your insurance carrier.

**FINANCIAL RESPONSIBILITY.** In return for services rendered to me by North Texas Physical Therapy, I promise to pay North Texas Physical Therapy in accordance with bills or invoices presented. I understand physicians, suppliers, and practitioners will bill and collect separately for their services. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan including all co-payments and deductibles and for any services that my plan may exclude from payment including supplies either because the plan deems such services are not medically necessary or for any other reason. I recognize and accept complete responsibility for any balance remaining after the payment of correct benefits by the insurance company. Payment can be made in the form of cash, check, and or credit card (Visa/MC). There will be a \$25.00 fee per check for all returned checks.

**(Check all that apply)**

**Assignment of Benefits.** I assign North Texas Physical Therapy all benefits payable to me under my insurance policies and health benefits plan.

**Medicare Assignment.** I certify that the information given to me in applying for Medicare Benefits is correct. I request that payment of authorized benefits be made directly to North Texas Physical Therapy.

**Workers Compensation.** The Workers Compensation Commission regulates fees and charges for medical aid, health care and medicines. For those services provided which the commission determines not to be related, I understand that I am financially responsible. In the event of such determination, the following insurance may be filled with benefits payable to the provider of service:

**Self Pay**

NORTH TEXAS PHYSICAL THERAPY, PLLC

Patient Consent Form

REQUEST FOR "NO INFORMATION" STATUS. I request "No information" status, which means that my name and my presence at North Texas Physical Therapy will not be divulged, except for judicial process. \_\_\_ No, it is ok to divulge information \_\_\_ Yes I want "no information"

MEDICAL INFORMATION AND DISCLOSURE. I understand that medical information about my condition and treatment may not be released except in situations as described in the notice of Privacy Practices, unless I give my permission as provided below:

\_\_\_ I authorize the physical therapists to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination, and treatment for all related illnesses.

\_\_\_ spouse \_\_\_\_\_ \_\_\_ children \_\_\_\_\_  
\_\_\_ parent \_\_\_\_\_ \_\_\_ other \_\_\_\_\_

THE ABOVE CONSENT IS VALID UNTIL REVOKED OR CHAGED. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT AT North Texas Physical Therapy.

\_\_\_\_\_  
Signature of Patient (or Patient's Representative)

\_\_\_\_\_  
Date

\_\_\_ Verbal Consent Given

\_\_\_\_\_  
\*Witness (only if patient is incapable of signing)

\*If the patient is incapable of signing or gives verbal consent, please state reason why:

- \_\_\_ Minor (unmarried individual under the age of 18 years old)
- \_\_\_ Physically impaired
- \_\_\_ Cognitively impaired
- \_\_\_ Other \_\_\_\_\_ Relationship to patient \_\_\_\_\_

## **A Patient's Bill of Rights**

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his health care provider complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can reasonably expect to understand. When it is not medically possible to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the health care provider responsible for coordinating his care.
3. The patient has the right to receive from his health care provider information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient has the right to know the name of the person responsible for the procedures and/or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.
5. The patient has the right to create advanced directives, such as a living will.
6. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
7. The patient has the right to expect that all communication and records pertaining to his care should be treated as confidential.
8. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of the patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
9. The patient has the right to obtain information as to any relationship of his hospital to other health care and education institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, which are treating him.
10. The patient has the right to be advised if the hospital or health care provider proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
11. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians and other health care providers are available and where. The patient has the right to expect that the hospital or health care provider will provide a mechanism whereby he is informed of his continuing health care requirement following discharge.
12. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
13. The patient has the right to know what rules and regulations apply to his conduct as a patient.