

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 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.



Date: _____

Initial visit Medical History

Name (First Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone: _____ Cell: _____

E-mail: _____ Social Security Number: _____

Martial Status: S, M, D, W

Is your injury work related? Yes or No

Employer- _____

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

MEDICAL 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

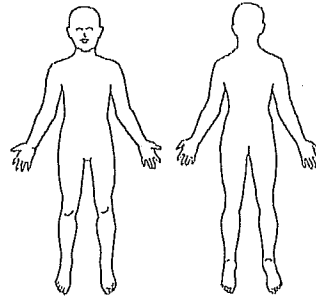
Are you currently working? ___ Yes ___ No If no, last day worked _____

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: _____



NORTH TEXAS

Physical Therapy

Please circle the following that apply to you:

Cardiovascular System	Yes	No	GI System	Yes	No
Elevated cholesterol	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
G.U. System	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	Pulmonary System	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	Endocrine System	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
Neurological System	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	Other Systems	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

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 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 will 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 to 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 100, Fort Worth, Texas 76132.

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