Patient Name: ______________________ Gender: ________
Date of Birth: ______________ Age: ________ Social Security#: ____________
Address: ______________________________________

____

____

Home Phone: ______________ Work Phone: ______________
Cell Phone: ______________________________________
E-mail address: ______________________________________
Can we send you occasional updates about our clinic/appointment reminders via e-mail? ❑ Yes or ❑ No

Employment: ______________________________________
Place of employment: ______________ Job Title: ______________

Primary Insurance:
Insurance Name: ______________ Policy Holder Name: ______________
Policy Holder Date of Birth: ______________________________________

Secondary Insurance (if applicable):
Insurance Name: ______________ Policy Holder Name: ______________
Policy Holder Date of Birth: ______________________________________

Worker's Compensation Patients:
Carrier Name: ______________________________________
Case Manager Name: ______________________________________
Case Manager's Phone Number: ______________________________________

Referring Physician: ______________________________________
If you have a follow-up appt. with referring physician, please write the date: ______________

May we send you appointment reminders through the mail? ❑ Yes or ❑ No
May we call your house to leave you an appointment reminder? ❑ Yes or ❑ No

I understand that Upstate Physical Therapy, PC will file my claims for services rendered to my insurance company. I agree to pay all fees not covered by the insurance company and will assume full financial liability if my insurance coverage does not cover Upstate Physical Therapy, PC services. I also authorizeUpstate Physical Therapy, PC to release portions of my medical records to the insurance carrier and/or payor of our services in order to secure payment. I also authorize Upstate Physical Therapy, PC to receive payment directly from my insurance carrier.

Signature: ______________________________ Date: ______________

Printed Name: ______________________________________

MEDICAL HISTORY

Current Condition:

Where is your pain? ____________________

When did it begin? ____________________

What caused your condition? ____________________

Is it work related? ____________________

Please list previous treatments and/or medications you are taking for your condition: ____________________

____

Have you had physical therapy in the past for this condition? ❑ Yes or ❑ No

If yes, please provide details (such as when you had physical therapy, what they treated you with and if physical therapy was successful): ____________________

____

Have you EVER or currently have one of the following conditions?

(Please check conditions that apply to you)

- ❑ Cancer
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Diabetes
- ❑ Stroke
- ❑ Heart Attack
- ❑ Congestive Heart Failure
- ❑ Acid Reflux
- ❑ HIV/AIDS
- ❑ Fibromyalgia
- ❑ Arthritis
- ❑ Seizures
- ❑ Other (please specify):

Do you have a pacemaker? ❑ Yes or ❑ No

Are you currently pregnant? ❑ Yes or ❑ No If so, how many weeks? ____________________

Are you allergic to latex? ❑ Yes or ❑ No

Do you have any known allergies to anything (including medications)? ____________________

Have you ever had surgery? ❑ Yes or ❑ No

If so, please list the surgeries you have had along with the approximate dates of your surgeries?

____

____

The above information is true and accurate to the best of my knowledge. Should my health condition change, I will notify Upstate Physical Therapy immediately.

Signature: ____________________ Date: ____________________

Consent to treatment:

I consent to the staff at Upstate Physical Therapy treating me. This includes an evaluation and treatment that is deemed appropriate by the licensed physical therapist at Upstate Physical Therapy. I understand that I have the right to refuse any treatment at any given time.

____________________________________ ____________________

Signature Date

____

Printed Name

NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Matthew Infanzon, Upstate Physical Therapy, 4401 North I-35, Suite 110, Denton, TX 76207 Phone (940) 483-9020

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

______________________________ ______________________________
Signature of Patient or Legal Representative Witness

______________________________ ______________________________
Date Date

HOW DID YOU HEAR ABOUT US?

Please tell us how you heard about our office:

____ I was referred to you by the physician ordering physical therapy.

____ I was referred to you by a physician other than the ordering physician.
Please list physician here: ____

____ Your office was recommended to me by a friend/relative.
Please list this person's name: ____

____ My insurance company gave me your information.

____ I found you in the phone book.
Which phonebook? ____

____ I found you on a search engine.
Which one (circle)? Google Yahoo Other: __________________________

____ I found you on your website.

____ I am a former patient of yours.

____ Other: ____

Screening for psychological services:

If you feel you need psychological counseling, our office can give you a list of resources to meet these needs. These services would be indicated for people who maybe experiencing depression, anxiety, suicidal thoughts or other emotional problems that are interfering with your life.
Do you have a need for these services?

❑ Yes ❑ No

PATIENT CONSISTENCY POLICY

Please note that physical therapy is most successful when the patient attends their treatments as advised by the physical therapist. Patients who are inconsistent with their treatments often do not receive the MAXIMUM BENEFIT from our services. We ask that you come to your appointments as scheduled and make up any appointments missed during the same week. If you have to cancel an appointment, please allow at least 24 hours notice, so that we can reserve that time slot for another patient.

I have read the above statement and will do my best to abide by this policy:

____ ____________________________

Signature Date

Medicare Patients Only

1. Are you or have you recently received home health services?

   ❑ Yes ❑ No

2. If you answered yes to the above question, please write the name and phone number of the home health agency:

   ____

   ____

3. How long did you receive home health services for?

4. What date were you discharged from home health?

5. Have you had OUTPATIENT physical therapy during the current calendar year?

   ❑ Yes ❑ No

6. If you answered yes to question #5 please tell us when you had outpatient physical therapy, how many sessions did you attend and for what condition were you treated for:

   ____

   ____

   ____

   ____