College Station Physical Therapy and Performance, PLLC

PATIENT CONTACT INFORMATION

Patient Name____Today's Date___________________

Address____________________________________City____________________ State_______Zip __________

DOB______________ Age________ Gender___________ Marital Status:_____________________________

Cell Phone _______________Home Phone ___________________ Email ______________________________

Employer____Occupation_________________________________

EMERGENCY INFORMATION - Parent/Guardian/Spouse/Nearest Relative:

Name ____

Address ___________________________________City____________________ State_______ Zip _________

Cell Phone _______________Home Phone ___________________ Email ______________________________

Employer____ Occupation________________________________

PATIENT QUESTIONNAIRE

Physician__________________________________Phone ____________ Email _______________________

From whom did you hear about us? ____

History of current condition ____

What is this condition most limiting you from doing that you need, want, or love to do?

____

List any tests that have been performed and the results (ie: X-ray, MRI, CT Scan, etc.) _____________________

____

Have you had any other treatments for your current condition?

- ☐ Physical Therapy
- ☐ Massage
- ☐ __________________
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ __________________

Please list practitioners: ____

____

What has had a positive effect? ____

What has had a negative effect? ____

Please list all previous injuries, accidents, surgeries (include year) and other pertinent medical info: _________

____

Please list all medical conditions and/or health concerns: ____________________________________

____

Please list all current medications: ____

____

Please list all allergies: ____

____

Medical History

Do You Now Have or Have You Had Any of These Symptoms in the Past Year? (Check all that apply)

- ☐ Change in Bowel Movements
- ☐ Persistent Joint Pain
- ☐ Unexplained Weight Loss
- ☐ Irritable Bowel
- ☐ Vertigo or Dizziness
- ☐ Persistent Nose Bleeds
- ☐ Learning Disabilities
- ☐ Tiredness/Fatigue
- ☐ Difficulty Sleeping
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Recurring Headaches

*Elaborate if Needed:*____

____

____

Dental History:

Dental History: (please elaborate when possible)

- ☐ Grind or Clench your Teeth?
- ☐ History Of TMJ Disorder?
- ☐ Ever Wear Dental Splint?
- ☐ Currently using a Night Guard?
- ☐ Popping or Clicking in Jaw?
- ☐ Jaw Ever Lock Up?

*Elaborate if Needed:*____

____

____

FOR WOMEN ONLY:

Please list number of:

- ☐ Pregnancies
- ☐ Children
- ☐ Date of Last Pelvic Exam
- ☐ Date of Last Pap Smear:____________
- ☐ Pap Smear: Negative
- ☐ Pap Smear: Positive

Any other pertinent information about pregnancies, complications with delivery, menstrual problems?

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CSPT OFFICE POLICIES & PROCEDURES

Welcome and thank you for choosing **College Station Physical Therapy and Performance (CSPT)** for your Physical Therapy needs.

Texas Law and the State of Texas Physical Therapy Board requires patients to have a written Referral from a licensed medical person (MD, DO, DC, DDS, DPM, ANP, PA). It is your responsibility to obtain and maintain a current referral prior to evaluation and during your treatments.

CANCELATION POLICY
As a courtesy to others and our Therapists and to other patients trying to get scheduled, we require a 24-hour (or greater) notice for cancellations. This allows others on waiting lists to be seen. Only emergencies or illnesses are excusable. **A $75 fee** will be billed upon violation of this policy.

CONSENT TO TREATMENT
CSPT is a hands-on Physical Therapy clinic. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of deep tissue massage, therapeutic exercise programs, gait training, neuromuscular re-education, cranio-sacral therapy, myofascial release, bone and soft tissue manipulation, trigger point dry needling, as well as other treatment modalities may be used.

Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern, however, please ask if you have any concerns or questions.

The number of treatments needed and recovery time can vary widely due to the age of injury, number of times injured, age of patient and many other contributing factors.

- ☐ I have read and fully understand the above statements. I understand the nature of the treatments at College Station Physical Therapy and Performance, PLLC and I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

PAYMENT AGREEMENT *(please check all boxes after reading)*
Thank you for choosing CSPT as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- ☐ **You agree to be financially responsible** for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- ☐ **Out-of-Network Policy.** CSPT is a fee-for-service clinic. This means that CSPT is not “in-network” with any private health plans. Payment is due at the time of service and we will not bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may submit to your private insurance company. Such receipts cannot be made available if you are a Medicare beneficiary (see Medicare Policy below).
- ☐ **Payment.** We accept cash, personal checks, and credit cards.

- ☐ **Medicare Policy.** If you are a Medicare beneficiary, you understand that our licensed physical therapists are not enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since the documentation and administrative processing of our services are not designed to meet Medicare's covered benefit requirements and we are not Medicare enrolled providers, our services will not be covered (paid) in full or in part, by Medicare (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider. We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. By choosing to receive our services after being fully informed of these facts, you are agreeing, of your own free will, that you do not want Medicare involved in payment for your physical therapy services at CSPT. You agree to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled provider. You also understand that since we are not enrolled Medicare providers and our documentation and administrative processes do not meet the technical requirements for Medicare to cover the services we provide, our services are not subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts, statements, or treatment notes to Medicare, a Medicare Advantage Plan, or to any primary-payer private insurance for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
- ☐ **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy and we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Disclosure to Release Protected Health Information form before we will disclose your health information.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE WRITTEN STATEMENTS AND PAYMENT TERMS.

X ____ Date: ____________________

Signature of Patient / Legal Guardian

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules HIPAA 143a-Authorization for Release of PHI 10-28-08

(1) **Patient's Printed Name:** ____

(2) **CSPT will only disclose** the protected health information you want disclosed.

Check only one box to tell CSPT the specific information you want disclosed/released:

- ☐ **Do NOT release any information** other than for treatment or payment *(skip #'s 3, 4, and 5)*
- ☐ **Limited information** (complete ALL Sections)
- ☐ **ALL records regarding my care at CSPT** to any requesting party *(skip #'s 3 and 4)*

(3) **Complete only if you selected "Limited Information".**

Please initial all that apply: Evaluation/Examination ________ Attendance_______

Correspondence re: Your Physical Therapy Services ________ Past Medical History _____

Treatments ________ Other ______________________________________

(4) **Complete only if you selected "limited information"**.

I only authorize the release of information to the individuals/entities identified below by name:

Spouse:______________________________ Attorney:______________________________

Parent:______________________________ Employer: ______________________________

Friend: ______________________________ School: ______________________________

Other: ______________________________ Other: ______________________________

(5) **Check only one box** indicating how long CSPT can use this authorization:

- ☐ Disclose my information indefinitely *(as long as CSPT has custody of my files)*
- ☐ Disclose my PHI for the following period beginning ___/___/_______ and ending ___/___/________

(6) **Please initial all items below** indicating that you have read and understand the rights or information below:

______I understand that this authorization does not expire unless I have indicated expiration date above.

______I understand that I can refuse to give authorization without fear of retaliation or treatment limitations._

______I understand that if I give authorization I may revoke it at any time by notifying this CSPT in writing

______I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession.

______I understand that if CSPT requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to.

______I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it _

CSPT will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose and intent

____________________________________ or ____________________________________

Signature of Patient Date Signature of Parent or Authorized Representative Date
(Indicate the Relationship)

You May Refuse to Sign this Authorization